R 9280-3F 12/86

TESTING THE SOCIAL SAFETY NET

Martha R. Burt

Karen J. Pittman

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The Impact of Changes in Support Programs during the Reagan Administration

Martha R. Burt
Karen J. Pittman

The Changing Domestic Priorities Series
John L. Palmer and Isabel V. Sawhill, Editors

THE URBAN INSTITUTE PRESS · WASHINGTON, D.C.

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THE URBAN INSTITUTE
2100 M Street, N.W.
Washington, D.C. 20037

Library of Congress Cataloging in Publication Data

Burt, Martha R.
Testing the social safety net.

(The Changing domestic priorities series)
Includes bibliographical references.
1. United States—Social policy. 2. Child welfare—United States. 3. Mentally ill—Services for—United States. 4. Aged—Services for—United States. 5. United States—Politics and government—1981-
I. Pittman, Karen J., 1952- . II. Title. III. Series.
HV95.B87 1985 361.6'1'0973 85-20878
ISBN 0-87766-392-0 (pbk.)

Printed in the United States of America
9 8 7 6 5 4 3 2 1

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FOREWORD

This book is part of The Urban Institute's Changing Domestic Priorities project. The project is examining changes that are occurring in the nation's domestic policies under the Reagan administration and is analyzing the effects of those changes on people, places, and institutions.

When President Reagan took office, he recognized that some individuals had a legitimate claim on public support. These were the "truly needy," people whose poor health, poverty, disability, or dependency (in the case of children) was so extreme, and their resources so limited, that government had an obligation to protect them. The "social safety net," as the president termed it, was to remain intact for such individuals.

This book examines the effects of changes made during the first Reagan administration on the well-being of selected needy groups in our society. It is one of several books and papers in the Changing Domestic Priorities project that focuses on how various groups, such as minorities, children, families headed by women, and the elderly, have fared under the Reagan administration.

To test whether the social safety net indeed remained in place, Martha R. Burt and Karen J. Pittman look at three populations—abused, neglected, and dependent children; the chronically mentally ill; and the low-income elderly—people who are considered needy and vulnerable by almost anyone's definition. Each population has in the past been the beneficiary of an array of federal programs, many of which were the target of administration changes in the early 1980s. The authors' intent is to trace the effects of federal changes through state and local governments to service delivery agencies and needy people themselves. The book assembles an extensive amount of empirical information describing the characteristics and needs of the populations studied, the pre-Reagan history of federal involvement in programs directed toward

helping them, and the changes enacted in these programs during the Reagan administration. Detailed information collected by the researchers in on-site visits to four geographically, economically, and politically diverse urban areas enables them to document the direct impact of recent changes on each population at the service delivery level.

The results of this assessment are discussed in the context of the administration's strong commitment to returning responsibility to the state or local level as well as the nonprofit sector and to increasing governmental efficiency. The question is raised whether, for the three populations studied, greater local commitment, more efficient program operation, or other factors have maintained an effective safety net or whether the shift away from federal involvement coupled with reduced federal financial resources has adversely affected the overall welfare of each group. The study concludes that these three populations have not been equally protected across the four jurisdictions investigated and that, in general, the necessity to serve more people with fewer resources has resulted in reduced local ability to maintain service levels.

In light of continued pressures on the federal budget and ongoing administration proposals to cut social welfare spending further, these results are instructive. As the debate goes on about the appropriate role of the federal government in providing a social safety net for the nation's most vulnerable citizens, both the local adjustments to, and the human costs of, federal retrenchment that are revealed in this volume should be carefully considered.

John L. Palmer
Isabel V. Sawhill
Editors
Changing Domestic Priorities Series

ACKNOWLEDGMENTS

Many people contributed to the success of this study. We thank Janet C. Gornick, Josephine Hobson, Madeleine H. Kimmich, and Sherry Sanborne for their assistance with data collection and agency contacts during our site visits to the four cities involved in the study. Terri Murray provided exceptional technical assistance in typing the manuscript. Agency and budget staff in all participating cities answered questions, organized meetings, provided agency records and updated material as new budgets were finalized, filled in the blanks, and generally were extremely cooperative. The manuscript reviewers contributed thoughtful and provocative comments and advice, most of which have been incorporated in the book.

The authors' own division of labor resulted in Karen Pittman having major responsibility for assembling the material and writing chapters 1, 2, 7 and 8; Martha Burt assembled the data for and wrote the remaining chapters. Both authors are jointly responsible for the introduction.

The support of the Ford Foundation and the John D. and Catherine T. MacArthur Foundation is gratefully acknowledged.

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Martha R. Burt, director of the Social Services Research program, a part of the Human Resources Policy Center at The Urban Institute, received her Ph.D. in sociology from the University of Wisconsin in 1972. Burt's work at the Institute has covered many aspects of the social service needs of vulnerable populations. She has focused on issues such as teenage childbearing and parenting, child and adult protective services, housing and day programming needs of disabled adults, emergency food and shelter programs, service needs of the elderly, and service needs of sexual assault victims. Her publications include *Private Crisis, Public Cost: Policy Perspectives on Teenage Childbearing*, numerous articles and reports, and congressional testimony.

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INTRODUCTION

The Reagan administration came into office with a plan to reduce the role of the federal government as overseer and provider for America's families and communities. Philosophically, the plan diverged from all administrations since President Franklin D. Roosevelt's New Deal of the 1930s in questioning the responsibility of government to promote general social welfare and assuage economic inequities. Its goals have been to reduce domestic spending sharply, to shift administrative, financial, and policymaking responsibility for most social programs to lower levels of government, and to ensure that the remaining federally supported programs serve only those clearly incapable of sustaining themselves without assistance. In enunciating these goals, the Reagan administration "took sides" on two important issues about the appropriate role of government in general, and the federal government in particular. The administration expressed a clear preference for private action over public action, and for local responsibility and control over federal responsibility and control.

According to administration views, if government removed itself from interference in social welfare issues, the private sector—including individuals, nonprofit agencies, and businesses—would be free to act in the best interests of needy citizens. Government was viewed as retaining some residual responsiblity to protect needy individuals, but the administration never clearly defined who deserved to receive this protection, nor did it specify how much and what kinds of protection should remain within the scope of federal responsibility.

The administration's preference for giving responsibility for social welfare programs to the private sector complements its preference for having local actors, either private or public, determine service priorities and raise the resources to meet them at the local level. Federal action was seen as

overly prescriptive, controlling, demanding, and as insensitive to local circumstances, resources, and values. Local control was perceived as being better able to target resources on those most in need and apply local priorities in the distribution of those resources. President Reagan never addressed the issue of horizontal fairness—whether individuals with identical needs but living in different localities would enjoy equivalent levels of support and assistance. Yet a primary argument for federal control over social welfare programs has long been that the nation as a whole has a responsibility to its neediest individuals and that the national government must act to assure that localities provide at least minimum levels of help to those in need.

The Reagan administration has at least partially achieved its goals of reducing spending for domestic social welfare programs and of returning control to local and state governments. The question, of course, is "at whose expense?" Have private individuals, charitable organizations, and businesses stepped in to provide supports for the needy? Have state and local governments protected from deprivation and want those who cannot help themselves? Have the needy been protected uniformly across jurisdictions or have local decisions resulted in levels of support demonstrably more uneven than before the federal government withdrew a significant amount of resources from social welfare programs? In this volume we attempt to answer these questions.

The work reported here is part of the much larger Changing Domestic Priorities (CDP) project at The Urban Institute that assesses the impact of the first Reagan administration on many aspects of social policy and practice. In this book we draw on material from the larger study and refer to other publications stemming from it when they provide more extensive treatment of particular complex issues than would be appropriate for our purposes. The special characteristic of our work is its focus on *needy populations* rather than on government programs. Individuals may be eligible for and receive assistance from a large range of programs and services. Our goal was to assess the cumulative impact of numerous program changes on the well-being of certain groups of needy people.

Focus on the Truly Needy

The Reagan administration set out to contain what it believed to be a slack and billowing "social safety net." The administration maintained that while some people receiving federal government benefits needed and deserved them, some significant amount of government assistance went to people who did not truly need it. Mistargeting, mismanagement, inefficiency, fraud, and abuse were blamed for absorbing unnecessarily large portions of available resources. Martin Anderson, assistant to President Reagan for policy devel-

opment during 1981 and 1982, describes the Reagan administration as "concerned about ensuring that people who cannot help themselves receive help."[1] He adds,

> When we call a program ineffective, we usually mean that the program does not work very well in achieving what we believe are essentially legitimate goals. Reagan's basic objective was to reform existing social welfare programs so that they could more effectively achieve their original goals. (p. 18)
>
> The objective is not to eliminate the programs. (p. 25)
>
> The objective is not to dump the programs on the states and localities, forcing them to raise taxes to whatever extent they can in order to continue programs.
>
> The objective is to improve the operation of those social welfare programs, and to reduce their costs, by returning responsibility and resources to a level of government more appropriate for these programs. (p. 25)[2]

With all the effort directed at changing programs perceived by the administration as inappropriate, has the social safety net held strong for those whom most people consider deserving of its protection?

For the purposes of this study we have assumed that being without financial resources and being unable to live or work independently by reason of age or disability qualifies a person as truly needy, especially when coupled with the absence of someone else who can fulfill a caretaker role.

This criterion encompasses more people than we had the resources to include in this study, so some further narrowing of focus was imperative. After careful consideration of the many possibilities, we decided that we should include one group from each of the broad categories of the young, the old, and the disabled. In our society, each of these broad categories of people is perceived as less able and more vulnerable than "normal adults." Within each broad category we looked for a clearly definable subcategory that was both highly vulnerable and traditionally the recipient of some form of government assistance to reduce their vulnerability. The final choices were (1) abused, neglected, and dependent children, (2) the chronically mentally ill, and (3) the low-income elderly. These three populations can be considered needy and deserving of assistance by most people's definition. We explored the effects of Reagan administration policy and program changes on the well-being of these selected groups.

The first population—abused, neglected, and dependent children—is children whose parent(s) chronically fail to provide them with the minimal

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1. Martin Anderson, "The Objectives of the Reagan Administration's Social Welfare Policy," in D.L. Bawden, ed., *The Social Contract Revisited* (Washington, D.C.: Urban Institute Press, 1984), p. 17.

2. Anderson, "*The Objectives.*"

necessities of life (neglected children), children whose parents actively abuse them physically (abused children), or children who have been removed from parental custody (dependent children). Our culture perceives all children as vulnerable, but they are not expected to provide for their own welfare; their parents are expected to take care of them. When parents fail or refuse to support their own children or actively abuse them, those children usually have no recourse to anyone but government for protection. They are among the most vulnerable of individuals because they have neither the maturity nor the skills to protect themselves, and they have lost their natural protectors—a caring parent or parents.

The population of abused, neglected, and dependent children includes many poor children, but is not limited to the poor. Children in poverty, another subgroup of the larger category of the young, are the subject of another publication in the Changing Domestic Priorities series.[3]

The second population—the chronically mentally ill—is defined as adults wholly or partially unable to maintain "normal" levels of productivity and self-sufficiency. A vast number of disabling conditions exist, from those that constitute mere annoyances to those that completely incapacitate their victims. We selected chronically mentally ill adults as our second population because the condition is seriously disabling, affects a sizable number of people directly and a much larger number of family members indirectly, and is often misunderstood.

The chronically mentally ill suffer from a disability that often leaves them unable to tolerate the stresses of normal work and family life, unable to care for themselves or to act in their own best interests, and sometimes unable to maintain contact with reality. Under the best of circumstances their condition can be stabilized enough to enable them to live peacefully in the community, but stress and uncertainty may result in repeated short- or long-term hospitalization. Many have no network of family or friends on whom to rely for care, and many have only an erratic work history, or no work history at all. Their disability renders them vulnerable; frequently isolation means they have no one to support them; and government programs, if available, are often their only resource.

Our third population is the low-income elderly. Our society generally perceives the elderly as less capacitated than their younger cohorts, regardless of their true state of competence. Many elderly people remain healthy and active, and a large proportion also has financial security. Among the elderly,

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3. Madeleine H. Kimmich, *America's Children: Who Cares? Growing Needs and Declining Assistance in the Reagan Era* (Washington, D.C.: Urban Institute Press, 1985).

those with low incomes are more vulnerable to disruptions and reductions in their quality of life from many causes.

People in this group have usually earned all they are going to earn in their lifetimes and frequently live on fixed incomes just barely adequate to meet their regular expenses. Many have chronic illnesses or disabilities that restrict their activities or that partially or totally incapacitate them. While many have existing family and support networks, others live alone or far from family members. The older they are, the more likely they are to be isolated, incapacitated, and poor. Any extraordinary circumstance, and even some predictable ones, are likely to strain their resources beyond their capacity. Serious illnesses or injuries, winter heating bills, rising property taxes, or simply increasing disability due to various conditions accompanying advancing age pose major threats to the well-being of the low-income elderly.

We selected these populations because, in addition to meeting our criteria for defining people with important claims on government for protection and support, they meet several other criteria. They contain sizable numbers of individuals in need of assistance. They all have complex service needs that under existing institutional arrangements cannot be met without drawing on multiple sources of funding and often multiple service providers. Because of these complex needs (needs for housing, income assistance, health and social services), small changes in benefits and services from individual programs can have large cumulative impacts. Finally, all have been targets of important federal programs that the Reagan administration has changed in significant ways.

Approach

The guiding question in this volume is, "what has happened to services for these three populations?" Answering this question inevitably leads to discussions of changes in the funding, administration, and regulation of the many federal programs that serve these populations. The focus of the book, however, is on changes in the levels, types, and adequacy of supportive services available to these populations, not on changes in programs. The provision of comparable or consistent services is at the heart of the Reagan promise to maintain government support for highly vulnerable groups. As Martin Anderson articulates the administration's goals, *more effective programs* pursuing the same goals was the objective.[4]

4. Anderson, "*The Objectives*," pp. 18, 25.

How could services for the truly needy have remained intact in the face of federal cuts in program budgets and policy changes affecting eligibility, services covered, and maximum allowable costs? Several possible adjustments could have occurred, either separately or in combination, that would have left services for the three selected populations at levels comparable to those existing before Reagan took office.

First, federal cuts and regulatory changes may not have affected these populations, although policy changes may have reduced services to other populations. Second, states and localities could have raised local revenues to replace federal cuts directed toward these groups. Third, states and localities could have shifted their priorities so that the reduced level of funding was targeted more specifically on services for these populations (albeit other populations would then experience disproportional cuts in service). Fourth, states and localities may have offset reduced funding by increased administrative efficiency and service coordination. Fifth, states and localities may have shifted clients to open-ended federal programs when categorical federal funds were cut. Thus services would continue and the federal coffers would continue to pay for them, despite the federal intent to reduce its commitment to financing these programs. Sixth, the nonprofit sector may have filled the gap left by loss of federal support.

This sort of shifting, setting priorities, and belt tightening is very much in line with the Reagan administration's goals to reduce domestic spending overall and to transfer responsibility for domestic social programs to states, localities, and the private sector. If public and private agencies in states and localities have taken enough of these actions to protect services for the truly needy, we would conclude that the administration's faith in the "new federalism" was sound, and that its domestic policies were successful.

At a different level of action, support for needy populations could have been maintained, or even improved, by fundamental redesign or reform of programs at the federal level. Observers have long criticized the ability of public programs to meet the needs of the three populations under study here. For example, years of dissatisfaction with child welfare services, excessive use of foster care, and low frequency of adoption had culminated in the Adoption Assistance and Child Welfare Act of 1980 just before Reagan assumed the presidency. Deinstitutionalization of the chronically mentally ill had proved unsuccessful from the point of view of the individual welfare of former mental patients because communities did not have programs to make stable community residence feasible. Families were experiencing great strain in caring for their poor and frail elderly members; many elderly had lost family members and had no one to take care of them; and resources to provide health care and social supports were severely strained. The Reagan admin-

istration, in its avowed desire to improve program effectiveness, might have undertaken a thorough review and overhaul of critical programs for these populations in an effort to better achieve the program goals of helping people who cannot help themselves. In subsequent chapters we look at the extent to which this happened.

Certainly the pre-Reagan mix of services was not optimal. It is possible that budgetary pressures could force agencies to redesign their services in ways that constitute absolute improvements over previous arrangements. However, we would judge that offering fewer services, in the face of stable or increased need, indicates an actual reduction in the level of commitment to protect the truly needy. The ultimate test of success lies in documenting actual changes in services to the populations under study and determining whether programs have been able to maintain or increase their assistance to needy individuals in accordance with program goals.

Documenting changes in services requires an understanding of the needs of the populations being studied. Next, a thorough knowledge is required of the programs that cumulatively serve these populations, including the changes these programs have undergone during the Reagan years. Most important, information is needed from the local level on changes in services—changes in numbers of clients served, in the quality, quantity, coordination, or timeliness of the services, and in the relation between public and private funders and service providers.

Documenting changes in federally funded, regulated, or administered programs is a formidable task. Documenting changes in services to specific populations supported by those programs is nearly impossible. We must move from the black and white of budgets and numbers served to the grayness of impressions, conjectures, and waiting lists. Clinicians, practitioners, and case workers—those providing or coordinating the services for the elderly, the mentally ill, and the children coming into the child welfare system—seldom have time to document the changes they are trying to handle. Nonetheless, it is with them that the story lies. This volume, therefore, presents a combination of impressions and numbers.

Methodology

Since service delivery occurs at the local level, we went to four cities and their surrounding counties in order to gather data on the impact of federal changes. The choice of cities was constrained by several factors. Primary among these was a large research effort under way at The Urban Institute—the Changing Domestic Priorities project—to trace the impact of Reagan administration policies and actions, of which this study is a small part. The

project involved a sample of eighteen states, so the cities chosen for this volume had to be in those states. This condition meant that researchers at the city level would have a great deal of state-level data available from other components of the project. In addition, several other project components would also use city-based data, so the cities had to meet the research needs of a variety of people. Cities had to be geographically diverse. A variety of different fiscal conditions and governmental philosophies was desirable. Based on these considerations, the four cities chosen were San Diego, Richmond, Detroit, and Boston.

These four cities (or, more accurately, urban areas because their respective surrounding counties are included in the data) differed substantially in their economic structure and condition.[5] Boston's economy is expanding and is driven by high-technology manufacturing and financial, medical, and educational services. Detroit is heavily dependent upon manufacturing, and particularly automobile manufacturing. It suffers disproportionately from cyclical downturns and is, in addition, experiencing longer-term problems due to foreign competition. Richmond's economy is stable and diversified, with state and local government the largest employer and the Phillip Morris Company the largest private employer. San Diego has experienced explosive growth, driven both by military installations and defense contractors and by high-technology manufacturing, particularly in the electronics and biomedical industries.

The long-term fiscal situation of local governments in the areas has reflected the condition of their local economies, institutional constraints, and political cultures. San Diego and Boston have been constrained by state limitations on local revenue raising (Propositions 13 and $2\frac{1}{2}$, respectively). San Diego's political culture might best be termed as aggressively conservative with a preference for market-oriented solutions and a small governmental role (except for environmental and amenity issues). Boston's spending levels, until constrained by Proposition $2\frac{1}{2}$—which placed severe limits on use of the property tax—have been characterized by traditional northeastern liberalism. Detroit's fiscal situation has been seriously affected by the decline of the automobile industry since the late 1970s. The duration and severity of the resulting revenue shortfalls have mitigated Detroit's traditional union-oriented liberalism and propensity for high levels of public spending. Richmond, a consolidated city-county, perceives itself as constrained from increasing its tax rates and thus its spending because of tax competition with surrounding

5. This paragraph and the next one are taken from Harold Wolman, "The Urban Impact of Federal Policy during the Reagan Era: Evidence from Four Case Studies," Urban Institute Working Paper (Washington, D.C.: Urban Institute, 1984).

suburban counties. Richmond's political culture is dominated by traditional conservatism with a preference for low taxation and spending.

In each city and county we determined which agencies served each of the three selected populations. We interviewed managers and case workers from government agencies who were primarily responsible for the well-being of the populations. We also interviewed staff of private agencies and organizations serving the populations, and advocacy groups if they were available. We collected budget and caseload data for the years under study (1981 to 1983), and also gathered extensive impressions, anecdotes, and explanations of what was happening to agency clients.

The Plan of the Book

This volume is organized into three parts. Part I focuses on abused, neglected, and dependent children; part II, on the circumstances of the chronically mentally ill; and part III looks at the low-income elderly. Each part is further divided into three chapters. The first chapter in each part describes the population; the second chapter, the major federal programs affecting the population with details on the changes that have taken place in those programs at the federal level under the Reagan administration; and the third chapter, the impact of federal program changes on the population at the local level, using the data collected from our case studies in four cities. The concluding chapter of the book summarizes the findings and discusses them in light of administration goals and promises.

PART ONE

CHILDREN IN THE CHILD WELFARE SYSTEM

CHAPTER 1

WHO ARE THE ABUSED, NEGLECTED, AND DEPENDENT CHILDREN?

The past ten to fifteen years have seen tremendous strides in public, governmental, and professional concern for vulnerable children, yet the number of abused and neglected children has continued to grow, and children who need substitute care have placed heavy burdens on welfare agencies. Who are these children? What is being done to help them, and is it enough?

As commonly understood, *neglected children* are children whose parents show chronic and long-standing failure to provide them with the necessities of life, while *abused children* are children who are exposed to physical harm or endangerment. *Dependent children* are children who receive substitute care—that is, those living in foster homes, group homes, or institutions rather than with their families. In the parlance of child welfare agencies, children in substitute care are dependent on the state, not their parents.

This chapter describes these vulnerable children, looks at the size and composition of the populations of abused and neglected children and children in substitute care, examines characteristics of these populations such as family income and race, and identifies their special needs. Chapter 2 outlines the development of federal legislation and programs affecting these children and discusses changes proposed or enacted by the Reagan administration. Changes in actual services offered to these children are reviewed in chapter 3.

The Populations of Vulnerable Children Defined

Reliable figures on the total size of the population of vulnerable children are not available. Many but not all states report child abuse and neglect cases to the federal government, but until quite recently (1982 or later) states did not reliably record the numbers or status of children in foster care. The data we have come from special studies commissioned by the Department of Health

and Human Services. These studies did not consistently cover every year, nor did they always report the same data in the same format. Even more important, they did not always report the reasons for placing children in substitute care, so the overlap in the abused and neglected population and the substitute care population can only be estimated. The remainder of this chapter contains the most precise estimates available, even though some figures are from the 1970s.

Annual estimates of the number of abused and neglected children in the United States in 1981 placed the number at more than 850,000, compared to about 416,000 in 1976—an increase of 104.5 percent over a five-year period. Between 1977 and 1982, children in substitute care dropped from 502,000 to 243,000—a decrease of 51.6 percent. The majority of this decrease occurred between 1977 and 1979. Even so, approximately a quarter of a million children were in substitute care each year between 1979 and 1982 (table 1).

TABLE 1

ESTIMATES OF THE NUMBERS OF ABUSED AND NEGLECTED CHILDREN AND CHILDREN IN SUBSTITUTE CARE IN THE UNITED STATES, SELECTED YEARS, 1976–82

Reported Cases of Abuse and Neglect		*Children in Substitute Care*	
Year or Period	*Number*	*Year or Period*	*Number*
1976	416,033	1977	502,000
1977	516,142	1979	301,943
1978	614,291	1980	273,913
1979	711,142	1981	273,000
1980	788,000	1982	242,897
1981	850,980		
1976–81 (percent change)	104.5	1977–82 (percent change)	−51.6

SOURCES: The reported cases of abuse and neglect for all years except 1981 are from American Humane Association, "National Analysis of Official Child Neglect and Abuse Reporting" (Washington, D.C.: Department of Health and Human Services, 1979); the 1981 figure is from U.S. Department of Health and Human Services, National Center on Child Abuse and Neglect, *Guidelines for Policy and Programs* (Washington, D.C.: U.S. Government Printing Office, 1982). The national estimates of the substitute care population are from the following: 1977—Ann Shyne and Anita Schroeder, *National Study of Social Services to Children and Their Families* (Rockville, Maryland: Westat, Inc., 1978); 1979—Department of Health and Human Services, Office of Civil Rights, "Children and Youth Referral Survey of Public Welfare and Social Service Agencies" (Washington, D.C.: DHHS, 1980); 1980—Child Welfare League of America, Inc., "Foster Care Population for 1980: Final Estimate (New York: CWLA, 1983); 1981—Toshio Tatara, *Characteristics of Children in Substitute and Adoptive Care: A Statistical Summary of the VCIS National Child Welfare Data Base* (Washington, D.C.: American Public Welfare Association, 1983); and 1982—"Child Welfare Indicator Survey" (McLean, Virginia: Maximus, 1983).

These figures, chilling in their own right, are extremely sobering when one realizes that they are static, not cumulative, numbers. They represent the annual incidence of child abuse, neglect, and dependency. If one assumes that half of the cases seen by child welfare officials are new to the agency and half represent recurring or continuing problems, at present rates as many as one out of ten children would be neglected or abused and one out of thirty would be placed in substitute care at some point during childhood.

Abused and neglected children and children in substitute care represent only a subset of the vulnerable children receiving public social services in the United States. These children are at high risk of becoming statistics in abuse, neglect, or substitute care caseloads. In 1977 there were an estimated 1.8 million children whose families were receiving supportive services such as counseling or homemaker assistance, supplemental services such as day care, or substitute care services such as foster care or residential care (see table 2). The abused and neglected children and children in substitute care were the largest subgroups. In the same year there were 502,000 children receiving substitute care and more than 516,000 children receiving services following reports of neglect or abuse. These two figures represent somewhat overlapping populations, since about one-third of abuse and neglect cases are also in substitute care.[1]

We focus on abused, neglected, and dependent children because the quality and availability of services for these children stand as a barometer for services to all vulnerable children. These children have intensive service needs, and historical data indicate that they are likely to remain on the caseload rosters for years if aggressive actions are not taken by service providers soon after they enter the system. Services for these children have been singled out by both legislators and professionals during the Reagan administration as greatly in need of revision and expansion.

Characteristics of the Populations

Abused and Neglected Children

It is difficult to say whether the sharp increase in the number of reported cases of abuse and neglect between 1976 and 1981 reflects an actual rise in the incidence of abuse and neglect or changes in reporting rates. All sectors at all levels have focused both attention and funds on child abuse and neglect in recent years. As a result, the public has become more aware and more

1. Ann Shyne and Anita Schroeder, *National Study of Social Services to Children and Their Families* (Rockville, Maryland: Westat, Inc., 1978).

TABLE 2

CHILDREN AND THEIR FAMILIES RECEIVING SOCIAL SERVICES IN 1977
(*N = 1.8 million*)

Type of Service	*Percent Receiving Specific Children's Services of Those Receiving Any Service*
Substitute services	
Adoption	5
Foster family care	25
Group homes	3
Institutional care	4
Residential care	3
Emergency shelter care	n.a.
Supplementary services	
Day care (for purposes other than employment or training)	16
Day treatment	2
Supportive services	
Protective	33
Health	26
Mental health	9
Counseling	19
Educational	10
Transportation	11
Legal	0
Financial or employment assistance	0

SOURCE: Ann Shyne and Anita Schroeder, *National Study of Social Services to Children and Their Families* (Rockville, Maryland: Westat, Inc., 1978), table 3.2. Figures are rounded.

n.a. Not available.

willing to report abuse and neglect, state and local capabilities for processing reports have improved, and the definitions of abuse and neglect have been expanded to include emotional, sexual, moral, medical, and educational maltreatment in addition to physical harm or endangerment.

Reports striving to heighten public awareness of the problem repeatedly emphasize that every child is a potential victim; as noted in a recent report from Maine's Department of Human Services, "Child abuse and neglect occurs in urban, suburban, and rural areas, in all racial groups and in families

with a wide range of incomes. The incidence rate for overall maltreatment is almost identical for white children and black children."[2]

Patterns of Abuse and Neglect. Child abuse and neglect are often addressed as if they were a single phenomenon. Yet as Shyne and Schroeder note in their comprehensive study of social services to children, "the characteristics and circumstances of the children and the nature of the agency response in cases of neglect seem to differ sufficiently from those in cases of abuse to call for their separate consideration."[3]

Data collected in the late 1970s indicate that child neglect is twice as common as child abuse. Child abuse, however, transcends income levels. It is less closely linked with poverty (28 percent of abused children receiving services were from AFDC families, as opposed to 39 percent of neglected children; see table 3).

TABLE 3

COMPOSITION OF POPULATIONS OF ABUSED AND NEGLECTED CHILDREN, 1979 AND 1980
(*Percent*)

Category	*All Children, 1980*	*Children Receiving Services, 1979*	
		Neglected	*Abused*
Race			
White	79	63	67
Black	15	27	19
Other	7	11	14
Public assistance status			
AFDC recipient family[a]	6	39	28
Nonrecipient family	94	61	72

SOURCE: Data for all children in 1980 are from U.S. Bureau of the Census, *Statistical Abstracts: 1981* (Washington, D.C., U.S. Government Printing Office, 1980); Data for children receiving services in 1979 are from Shyne and Schroeder, *National Study of Social Services*. Figures are rounded.

a. Aid to Families with Dependent Children.

Abused children are more likely to be white than are neglected children. White children are underrepresented in both the abused and neglected populations, but they make up a slightly larger proportion of the abused population (table 3). Black children are only slightly more likely to be among the abused

2. Michael Petit and Donna Overcash, *America's Children: Powerless and in Need of Powerful Friends* (Augusta, Maine: Maine Department of Human Services, 1983), p. 64.

3. Shyne and Schroeder, *National Study of Social Services*.

population than their representation in the general population population would suggest, yet they are twice as likely to be part of the population of neglected children as their representation in the general population would indicate.

Incidence among Low-Income Families. Although abuse and neglect are universal threats to children, the incidence of child abuse and neglect is closely linked to poverty and to the stressful social, familial, and emotional problems that accompany it: "It is no accident that neglect, abuse, delinquency, and other definitions of social pathology are found in high proportions in neighborhoods where there is also an accompanying high level of infant mortality, poor educational achievement, low income, and inadequate health services. Also, there is the absence of viable social institutions that can provide the programs and resources that could help families cope with the day-to-day task of surviving in an urban environment."[4]

Data reported by the National Center on Child Abuse and Neglect indicate that the incidence of abuse and neglect is ten times higher among families with incomes below $7,000 than among families with incomes of $25,000 or more.[5] These figures probably overstate the actual differences in incidence rates because of the differential approach used in handling situations of suspected abuse and neglect in low-income as opposed to middle-income areas. Middle-income families are less likely than low-income families to appear as statistics in public reports because of their access to private sources of support (physicians, psychologists) and because of the reluctance of these private practitioners to comply with mandatory reporting laws.[6] Nonetheless, both statistics and research indicate an increased likelihood of neglect and abuse among low-income families. Families headed by a female single parent are at high risk for child abuse and neglect, contributing almost three times the number of cases that their frequency in the general population would suggest.[7]

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4. George Silcott, "Institutionalized Social Bankruptcy Equals Child Abuse, Therefore Today's Challenge: Family Life Preservation," in Michael L. Lauderdale et al., eds., *Child Abuse and Neglect: Issues in Innovation and Implementation*, Proceedings of the Second National Conferences on Child Abuse and Neglect, vol. 1. (Washington, D.C.: U.S. Department of Health, Education, and Welfare 1978), p. 15.

5. U.S. Department of Health and Human Services, National Center on Child Abuse and Neglect, *Guidelines for Policy and Programs* (Washington, D.C.: U.S. Government Printing Office, 1982).

6. Private physicians in Westchester, New York, for example, reported only 6 of the 891 cases investigated by child protective services staff in 1976. Data are from Silcott, "Institutionalized Social Bankruptcy."

7. Based on data for families reported for child abuse and neglect from American Humane Association, "National Study on Child Neglect and Abuse Reporting," annual report (Denver: AHA, various years); and data for all families from U.S. Bureau of the Census, *Statistical Abstract of the United States* (Washington, D.C.: U.S. Government Printing Office, 1981), tables 61 and 62.

There is considerable overlap between these families and public welfare recipients, strongly suggesting the role of poverty rather than single parenthood per se as a backdrop for abusive or neglectful behavior. The 7 million to 8 million children receiving AFDC (Aid to Families with Dependent Children) and the 12 million to 13 million children living in families below the poverty line at any given time constitute a vast reservoir of high-vulnerability children, some significant proportion of whom will receive child protective services (services resulting from an abuse or neglect report) before reaching age eighteen.[8]

Children in Substitute Care

Although exact counts are not available, it is clear from estimates made by a variety of sources that the number of children in substitute care is declining. The number may not have dropped as precipitously as the estimates suggest (about 50 percent between 1977 and 1982), but it has decreased as a result of national, state, and local efforts to keep families together when solutions are possible and to move children who are in substitute care into permanent living arrangements as quickly as possible.

The use of substitute care, like the incidence of neglect and abuse, is related to poverty, race, and single parenthood. In 1980, 40 percent of the children in substitute care were minorities (32 percent were black); 1977 data show that 38 percent of the children were from families receiving AFDC payments.[9] A 1978 study reported that 60 to 80 percent of the children in foster care had been receiving some form of public assistance before they entered the system.

Abuse and neglect stand out as the foremost reasons why children receive substitute care. Indications are that, as reporting rates increase, abuse and neglect may account for as many as half of the substitute care cases.[10]

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8. U.S. Congress, House, Select Committee on Children, Youth, and Families, *U.S. Children and Their Families: Current Conditions and Recent Trends*, 98th Cong., 1st sess. (Washington, D.C.: U.S. Government Printing Office, May 1983); and Jane Knitzer, Mary Lee Allen, and Brenda McGowan, *Children without Homes: An Examination of Public Responsibility to Children in Out-of-Home Care* (Washington, D.C.: Children's Defense Fund, 1978).

9. National estimates of the substitute care population are from the following: 1980 estimate from Child Welfare League of America, Inc., "U.S. Foster Care Populations for 1980: Final Estimate" (New York CWLA, 1983); 1977 estimate from Shyne and Schroeder, *National Study of Social Services*.

10. Administration for Children, Youth, and Families, "Child Welfare Research Notes no. 1: Characteristics of Children in Foster Care" (Washington, D.C.: U.S. Department of Health and Human Services, 1983).

The Special Needs of These Vulnerable Children

Reporting Abuse and Neglect, Community Efforts, and Agency Follow-up

Abused and neglected children stand out as truly needy even among other groups of vulnerable children because they need not only intensive services but widespread community awareness and cooperation in order to receive those services. Among the general population of children receiving all types of social services, about one-quarter of the cases were referred by parents.[11] The parents of abused and neglected children, however, rarely report themselves. Reports come frequently from nonprofessionals in the community—friends, neighbors, relatives. Medical, school, social service, and law enforcement personnel together account for about half of the reports.[12] Clearly, then, any efforts to help neglected and abused children must focus on the need for timely reporting and swift and thorough follow-up. The sharp increases in reporting rates during the past decade attest to the value of the general educational and organizational efforts to identify neglected and abused children and of the increased capability of agencies to follow up on reports. The National Center on Child Abuse and Neglect notes, however, that there is some evidence indicating an inverse relation between reports and resources; that evidence suggests "communities may respond by becoming less likely to report child maltreatment when they perceive that the response to the report will not be adequate."[13] Given the almost complete reliance of abused and neglected children on the voluntary efforts of community members for help, this perceived relation could be a serious problem.

Changing Attitudes: Deemphasis on Substitute Care

While the most distinctive changes in the nation's response to child abuse and neglect have been in community awareness of the problem, yielding higher reporting rates which begin the process that often culminates in substitute care placement, the most important changes in substitute care since the 1970s have been in the attitudes of those directly or indirectly involved in placement decisions. Legislators and professionals alike have begun to realize the importance of removing children from the substitute care system.

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11. Ibid., p. 49.

12. American Humane Association, "Study on Child Neglect and Abuse Reporting," annual report (Denver: AHA, 1979 and 1983).

13. Richard Blume, "Foster Care in the United States: The State-of-the-Art" (Washington, D.C.: Social Services Research Institute, 1981).

The problem is that the number of actors involved in the child welfare system—from individual caseworkers to state legislators to officials who set federal policy and funding priorities—makes it difficult to implement this philosophical change.

In 1975 the Children's Defense Fund conducted an extremely comprehensive investigation of the U.S. foster care system. The major findings of that study, briefly outlined below, have since been confirmed by numerous other studies.[14]

1. Removing a child from the home in a situation of abuse or neglect is often the easiest course. Funds for removal are available; funds for alternative services (day care, homemaker services, alternative housing, and so on) are often unavailable or inadequate.

2. When a child is removed from the home, placement with relatives is often not actively pursued. In some states foster care payments cannot be made to relatives, thus many children who could maintain family ties are denied the opportunity if relatives cannot afford to take them in without financial assistance.

3. Once a child receives substitute care, parents are not explicitly encouraged to maintain contact with the child; sometimes they are actively discouraged by agency regulations. Parents wanting to maintain contact are not helped by the agency. Transportation funds are not provided even though the child may be placed at some distance from the parents. Parents are not routinely kept informed about their children's progress. Sometimes they are not even informed when their children are moved.

4. While the child is in substitute care, parents generally obtain little help in alleviating the problems that led to placement. Funds for services that would enable the family to be reunited are seldom available.

5. Even when parental ties with the child have been severed, either because of abandonment by the parents or the inaction of public agencies, parental rights are rarely terminated. Thus the child no longer has meaningful contact with the parents, but the parents retain legal control of the child.

6. For the child who has had (or should have) parental rights terminated, efforts to ensure adoptive homes are often inadequate. Adoption efforts are hampered by fiscal barriers, inadequate funds for subsidized adoptions or

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14. See, for example, S. Vasaly, *Foster Care in Five States: A Synthesis and Analysis of Studies from Arizona, California, Iowa, Massachusetts, and Vermont* (Washington, D.C.: Office of Human Development, U.S. Department of Health and Human Services, 1976); Robert Mnookin, "Foster Care: In Whose Best Interest?" *Harvard Educational Review*, vol. 43 (1973); and David Fanshel and Eugene Shinn, *Children in Foster Care: A Longitudinal Investigation* (New York: Columbia University Press, 1978).

legal fees, and deeply embedded views that certain children—minority children, older children, and children with special medical needs—are "hard to place," and thus "unadoptable."

Although professional views on the treatment of child abuse and neglect cases have begun to deemphasize removing the child from the home and punishing the parents, substitute care may be necessary in instances in which a case-worker cannot satisfactorily guarantee that the child will be safe in the home while services are being provided. At least in theory, however, most child welfare agencies are now committed to using substitute care only as a last resort. While substitute care is the appropriate solution for some children with serious emotional, mental, or physical problems, a full three-fourths of the children in care are there not because of their problems but because of the problems of their caretakers.[15] This fact shapes the recommendations for the types of service perceived as preferable to substitute care.

Focus on Supportive and Supplementary Services

In place of substitute care the new perspective emphasizes a variety of supportive and supplementary services such as counseling, parent training, homemaker services, and day care, which combine to strengthen and stabilize the at-risk family. Professionals now realize the importance of focusing treatment efforts on *both* parents and children to break destructive family behavior patterns and provide all family members with new role models and coping skills. Among the specific services listed as possibilities for abused and neglected children by the National Center on Child Abuse and Neglect are early childhood programs; therapeutic day treatment for children with developmental delays, psychological problems, or both; special education for school-age children exhibiting emotional or learning problems; psychological counseling and therapy; and general community supports such as Big Brother programs and YMCA or YWCA activities.[16] For parents, parent education, family planning services, self-help groups, homemaker services, parent aides, crisis nurseries, and assistance with housing, transportation, and employment are just some of the possible supports suggested in addition to therapy. The emphasis is both on helping the parents change their behavior and on helping to remove some of the chaotic or stressful characteristics of their lives that provoke or exacerbate abusive or neglectful behavior.

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15. Cynthia Ragan, Marsha Salus, and Gretchen Schultze, *Child Protection: Providing Ongoing Services* (Washington, D.C.: National Center on Child Abuse and Neglect, Department of Health and Human Services, 1977).

16. Shyne and Schroeder, *National Study of Social Services*.

Many of these services are seen as "soft" services by state and local legislatures and by agencies themselves. Their value has yet to be firmly established; their applicability in specific cases is often questionable; and they require more coordination and case management effort than their alternative, substitute care. Expenditures for preventive services have increased in recent years, but they still represent only a fraction of the dollars spent on substitute care.

The Push toward Permanency: Some Results

The most telling characteristic of the substitute care population is not a characteristic of either the children or their families, but of the system itself. Substitute care is supposed to be a short-term, emergency solution; it should not be accepted as a permanent solution except in rare cases. Several studies have found that the prospects of reuniting parents and children diminish rapidly after eighteen months to two years. This relatively short timespan for durability of the family bond makes intensive preventive and early reunification efforts essential. Yet in 1982 the average length of time in care was almost three years (thirty-five months). This period is an improvement over the average length of time in 1977 (forty-seven months), but it is still a long time. In 1981, about 50 percent of the children who left substitute care returned home, but 33 percent left because they had reached the age of majority.[17]

Preplacement Services are now viewed as both legitimate and effective, although their use is still hampered by the lack of funds and clear guidelines for matching families with services. Reunification and adoption services have also been intensified as a result of the push by the professional community (spearheaded by the Children's Bureau of the Department of Health and Human Services) to see every child as potentially placeable in a permanent home. By 1980, legislation (The Adoption Assistance and Child Welfare Act) authorized funding for subsidized adoptions and for upgraded preplacement and reunification efforts.

This recent push toward permanent homes for abused or neglected children has not benefited all subgroups of the substitute care population equally, however. For some groups of children who have been in substitute care for years, now appropriately called "special-needs children"—including the handicapped, minority, and older children—adoption is their only hope for

17. Toshio Tatara, *Characteristics of Children in Substitute and Adoptive Care: A Statistical Summary of the VCIS National Child Welfare Data Base* (Washington, D.C.: American Public Welfare Association, 1981). The age of majority is sixteen, eighteen, or twenty-one years of age, depending on state and sex of the child.

permanency.[18] Assisting these children requires intensive and often unconventional outreach methods; in many cases, child welfare personnel must be reoriented to understand that these cases are worth the effort. For these children, adoption is often largely dependent on adoption subsidies, either because of the child's entry characteristics, such as presence of a medical condition, or the adoptive family's income.

An example of one group of special-needs children is children with a minority background. The percentage of the substitute care population that is minority has increased steadily since the mid-1970s.[19] Several studies suggest that this increase is at least partially due to differences in the nature and amount of effort put forth by the child welfare agencies, not in the entry characteristics of the children.[20] Minority children tend to remain in substitute care longer. If these children are Hispanic, they are less likely to have had their ties to parents legally severed even though they have been in such care longer; and once parental rights have been terminated, they are less likely to find adoptive homes. Thus, although some results of the emphasis on permanency are positive, more effort rather than less needs to be exerted if all children in substitute care are to benefit.

Summary

Child abuse and neglect reporting have increased dramatically since the mid-1970s, at the same time that foster care placements and the number of children in foster care have dropped by about half. Abuse and neglect are major causes of placement in substitute care.

Poverty, often linked to race and single parenthood, appears as a major factor in neglect cases, and a less dominant but still significant factor in abuse cases. The increasing numbers of families and children living in poverty during the early 1980s may be an important precipitating condition of increases in child abuse and neglect reporting. Expanded public awareness of the issue is undoubtedly another contributing factor.

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18. These children officially defined as having special needs are handicapped, minority, and older children, children with medical needs, and children who are members of a sibling group for whom placement together in a single foster home is deemed the preferred solution.

19. In 1977, 38 percent of this population was minority; in 1981–82, 46 percent. Figures are from, respectively, Shyne and Schroeder, *National Study of Social Services*; and from Tatara, *Characteristics of Children*, and "Child Welfare Indicator Survey" (McLean, Virginia: Maximus, Inc., 1983).

20. Arthur Emlen et al., "Overcoming Barriers to Planning for Children in Foster Care" (Portland, Oregon: Portland State University, U.S. Department of Health, Education, and Welfare, 1978); and Tatara, *Characteristics of Children*.

As the declining substitute care rates indicate, the child welfare system is responding to the need for prevention and permanency planning. The system, however, was not and still to a large extent is not designed to provide these services. Its strength is substitute care; it has a payment mechanism for substitute care; and inertia favors substitute care. Preference for substitute care was based first on the now outmoded belief that swift removal from an undesirable family setting was in the child's best interests. Now, by and large, continued reliance on substitute care responds to federal funding priorities that make such care the most financially attractive solution for local governments to use in resolving family problems (even though the costs of long-term substitute care far outweigh those of prevention, reunification, or adoption services). There is now a national child welfare policy that reflects current beliefs favoring active early intervention and prevention services, but child welfare services will be slow to respond to this legislation without the support of federal funds. The next chapter explores federal child welfare programs and policies.

CHAPTER 2

FEDERAL POLICIES AND PROGRAMS AFFECTING VULNERABLE CHILDREN

The 1960s and early 1970s saw a rapid growth in the federal financing of social services. Sparked by the Public Welfare Amendments of 1962, which legislated federal-state cost sharing for social services aimed at reducing or preventing dependency, federal expenditures soared. Between 1967 and 1972 federal expenditures grew from $281.6 million to $1.7 billion, a phenomenal increase even after allowing for inflation.

The federal role in financing children's services expanded concomitantly during these years. By the mid-1970s federal dollars accounted for about half of the total public spending on child welfare services. It was not until the enactment of P.L. 96-272, the Adoption Assistance and Child Welfare Act of 1980, however, that the federal government aggressively attempted to develop and implement a national child welfare policy.

The first and second sections of this chapter briefly outline the federal activities in child welfare before the 1980 act, summarize the changes created by the act, and discuss the effects of the law based on its first years of implementation. The third section details the changes and attempted changes in child welfare legislation and funding during President Reagan's first term.

Federal Involvement in Child Welfare, 1960–79

The Social Security Act of 1935 marked the first venture of the federal government into child welfare. Title IV(A), Aid to Dependent Children (later Aid to Families with Dependent Children, or AFDC), specifically addressed the financial needs of children in families deprived of parental support. Title IV(B), Child Welfare Services, encouraged states to develop, strengthen, or expand preventive and protective services for all vulnerable children, regard-

less of income, by providing limited federal funds to states through formula grants.

1960–69

In the 1960s legislation was enacted that substantially increased federal financial involvement in child welfare. As many excellent reports have made clear, however, these efforts served to encourage what in the late 1970s became widely publicized as a "national disgrace"—the rampant and often indiscriminate placement of children in foster care.[1]

1961—AFDC Foster Care, Title IV(A). In 1961 Congress passed legislation requiring states to provide foster care as part of their AFDC programs. Federal funds were available for room and board (maintenance) costs only, not for preventive, reunification, or even case-management services; these funds were available only when the child had been removed from the home as a result of a judicial determination, that is, not placed in care under a voluntary agreement with parents. By 1979, the total cost of caring for 104,000 of the estimated 300,000 children in foster care who were AFDC Foster Care recipients was more than $350 million, about half of which was federal funds.[2] The AFDC legislation significantly eased the burden of substitute care costs for states, but because few demands were placed on states to either justify or limit foster care, and limited federal effort was devoted to encouraging the use of alternative services, this open-ended source of funds reinforced the premature and often prolonged use of foster care as a solution to family problems.

1965—Medicaid, Title XIX. With the creation of Medicaid, medical assistance was extended to AFDC children in foster care. Again, while easing states' financial obligations and ensuring that children in care would receive adequate medical attention, this legislation inadvertently created an additional disincentive to permanency planning for AFDC Foster Care children—these children would now lose both maintenance reimbursements and medical coverage if adopted by families whose incomes were over the eligibility cutoffs for these programs.

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1. Jane Knitzer et al., *Children without Homes: An Examination of Public Responsibility to Children in Out-of-Home Care* (Washington, D.C.: Children's Defense Fund, 1978); and Joseph Persico, *Who Knows? Who Cares? For Other Children in Foster Care* (New York: The National Commission on Children in Need of Parents, 1979).

2. The 1977 data cited in U.S. Congress, Senate, Committee on Finance, *Report on the Adoption Assistance and Child Welfare Act of 1979*, 96th Cong., 2d sess. (October 2, 1979), lists the federal share as 52 percent (table 1).

1968—Emergency Assistance Program. Title IV(A) of the Social Security Act was amended in 1968 to include an emergency assistance program that allowed states to provide services to families in crisis, including emergency shelter care and financial assistance. States could establish their own eligibility requirements. Federal matching funds were made available for emergency assistance provided for a maximum of thirty days in any twelve-month period. This program had the potential of keeping children out of long-term care by providing timely and targeted assistance. It was never fully implemented, however. Ten years after the legislation was enacted only half of the states were participating in the program (many states, however, used IV(B) monies for emergency shelter). Federal expenditures in 1978 were only $40 million.

1970–79

The 1970s saw a shift in federal involvement in child welfare. As research began consistently to document the substantial disparities among existing state and local programs, the federal government attempted to take a more active role in shaping the nature and quality of services provided to vulnerable children.

1972—Increased Authorization for Title IV(B). In 1972 Congress increased the authorization for funding child welfare services under Title IV(B) in an effort to encourage states to develop and expand supportive, protective, and preventive services, thereby decreasing reliance on foster care. Slightly less than $200 million was authorized for fiscal 1973, rising to $266 million in fiscal 1976 and thereafter. Appropriations did not come close to authorized levels, however, growing only from $45 million in 1970 to $56.5 million in fiscal 1979 (an actual decrease of 38 percent after adjusting for inflation). The language of Title IV(B) is progressive, encouraging states to "establish, extend and strengthen public social services which supplement parental care and keep families intact." But the low level of funding, combined with the lack of enforceable restrictions on the use of IV(B) funds, rendered the legislation ineffective as a control over state actions. Title IV(B) funds represent only 5 percent of total expenditures for child welfare. Without tight federal restrictions, the states have overwhelmingly used them to pay for substitute care. In fiscal 1976 less than 20 percent of federal Title IV(B) funds was spent on nonemployment-related day care, protective services, or adoption services.[3]

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3. U.S. Department of Health, Education and Welfare, Public Service Administration, Social and Rehabilitation Service, "Child Welfare Expenditures by Type of Service, Fiscal Year 1976," (Washington, D.C.: DHEW, 1976).

1972—Cap on Social Services Expenditures. As noted at the outset of this chapter, the Public Welfare Amendments of 1962 created a major surge in federal social services spending. A doubling of expenditures between 1971 and 1972 ($741 million to $1,688 million) led Congress and the administration to place a $2.5 million cap on social services expenditures in 1972. This cap made it even more difficult for states to develop and use services that were alternatives to foster care.

1974—Child Abuse Prevention and Treatment Act (P.L. 93-247). This act established the National Center on Child Abuse and Neglect as the focal point for federal efforts to address the growing number of reports on abuse and neglect that, by the mid 1970s, had clearly evolved as a national problem. Authorized at $85 million for a four-year effort ($15 million in fiscal 1974; $20 million in fiscal 1975, $25 million in fiscal 1976 and in fiscal 1977), the act also provided funds to assist states, localities, and nonprofit organizations to develop preventive programs and services for abused and neglected children and their families. To be eligible for grants, states had to meet specific reporting and procedural requirements. This program, unlike IV(B), has been funded close to the authorization levels ($18.2 million in fiscal 1977).

The act has been quite effective in producing nationwide reform in public awareness of and states' responses to reports of abuse and neglect, as the increases in the number of reported cases described in chapter I suggest. The act does not, however, address services or procedures for children brought into the child welfare system as a result of these reports.

1975—Grants to States for Social Services, Title XX. Congress made a major effort in 1975 to improve state services to intact families, thereby hoping to reduce current and future dependency, through passage of another amendment to the Social Security Act, Title XX.[4] Although it did not focus specifically on children, Title XX was seen as a landmark step toward developing comprehensive and effective social services for neglected, abused, and dependent children and adults.

Under Title XX the states were given increased authority, responsibility, and flexibility in choosing and running programs and in defining the populations eligible for these programs. Title XX allowed a broad range of services (child care, protective services, foster care, homemaker services, transportation, training and employment services, nutrition and health-support services, family planning services), and opened up eligibility considerably. Service beneficiaries could be recipients of AFDC, Supplemental Security Income, or Medicaid and could also

4. Title XX combines the open-ended entitlement programs, which were part of Title IV(A) emergency assistance and services to AFDC families, and Title XVI services for the aged, blind, and disabled, and Supplemental Security Income recipients.

be any persons earning no more than 115 percent of the state median income (recipients earning between 80 and 115 percent of the median had to be charged for services, however, and 50 percent of the service recipients had to be on AFDC, Supplemental Security Income, or Medicaid rosters).

Title XX, like Title IV(B), had the potential of encouraging states to develop or strengthen prevention, protection, and permanency planning (reunification or adoption) services for children. The $2.5 billion cap on social service expenditures enacted in 1972, however, remained in effect under the new legislation, making Title XX more like a compromise that gave states flexibility than a new federal effort to lead states. By 1977 thirty of the fifty states had reached their spending ceiling—many had been at the ceiling for several years—and were effectively barred from developing new programs or expanding client eligibility using Title XX support unless they shifted money from some other services for that purpose.

Title XX, nonetheless, is a major source of social services funding for vulnerable children and their families. Title XX supplied approximately 30 percent of the budget for state child welfare services by 1982, compared to 52 percent from state, local, and private sources and 18 percent from other federal sources (Title IV(B), Title IV(E/A0, and other miscellaneous federal funds). On average about one-third of Title XX recipients are children; they receive about one-half of the Title XX dollars. Even though Title IV(B) has child welfare as its focus, Title XX has been the effective federal funding source for child welfare services since its enactment.

To summarize, by the end of the 1970s the federal government had enacted several pieces of legislation intended to encourage the development of preventive, protective, and reunification or adoption services, but that legislation provided few financial incentives or regulatory mechanisms for states to fully implement these alternatives to foster care. AFDC-Foster Care remained an open-ended entitlement program while Title IV(B) child welfare services and Title XX faced limited funding and could not adequately support the development of services for children in line with the legislative intent. When the decade closed, nearly three-fourths of all child welfare monies were devoted to foster care. Although some states were making significant strides in reducing their foster care loads through administrative reform and development of alternative services, there was no strong, unified push from the federal government for this to happen across the board.

The Adoption Assistance and Child Welfare Act of 1980

The most significant development in federal policy for child welfare occurred in 1980 when Congress approved the Adoption Assistance and Child

Welfare Act (P.L. 96-272). The act set forth a comprehensive set of standards for child welfare, stipulating improved casework practices and new protections and services for children in the system. As one official at the Department of Health and Human Services put it, "For the first time, the legislation reaches down and directly affects the experience of the individual child who comes in contact with the system."[5] By October 1983, state plans were supposed to demonstrate that reasonable preventive efforts had been made for each child prior to out-of-home placement and that reasonable efforts had been made to reunite family and child.

In addition to planning requirements aimed at ensuring more limited and appropriate use of out-of-home care, the 1980 legislation presented a set of fiscal incentives to help shift the service emphasis away from foster care. First, the act provided federal reimbursement for adoption subsidies for AFDC children with "special needs" (usually defined by states as older, minority, or handicapped children or children who are members of sibling groups and need to be kept together) and for continued Medicaid coverage after adoption (until age eighteen). While forty-five states already had some type of adoption subsidy program in place, this provision formally removed the financial barrier that kept many children in foster care.

Second, the act placed a conditional ceiling on federal support for foster care maintenance. Federal matching funds for AFDC foster care payments under Title IV(A) had been available to states on an open-ended, entitlement basis. The new legislation, which replaced Title IV(A) Foster Care with new Title IV(E) foster care and adoption assistance, sought to reduce the use of foster care in favor of preventive efforts by capping federal foster care funds when appropriations for Title IV(B) child welfare services reached specified amounts. For fiscal 1981 the trigger was $163 million; it was $220 million fiscal 1982, and $266 in fiscal years 1983 and 1984. In effect, the trade-off was more money for prevention, but less for foster care.

Third, the act allowed states to transfer unused foster care maintenance funds (funds below the state's ceiling) to child welfare services.

Fourth, the act ensured that increased Title IV(B) funds would go only to states conforming to the new state plan procedures and that these additional funds (above the states' pre-P.L. 96-272 share of $56.6 million, the 1980 allocation) would not be used for foster care maintenance, adoption assistance, or employment-related child care. Also, to be eligible to receive its share of the increased Title IV(B) appropriation, a state had to maintain its 1979

5. Margot Schenet "Federal Expectations for P.L. 96-272: Child Welfare Reform," Working Paper (Washington, D.C.: Urban Institute, October 1982).

spending level—it could not use the new federal dollars to replace state dollars.

Fifth, the act increased the federal matching rate for IV(B) funds to 75 percent. The rate had varied from 33 to 66 percent.

In 1981, the act's first funding year and the last year controlled by the Carter administration, Title IV(B) appropriations jumped from $56.5 million to $163.5 million—the level necessary to trigger the ceiling on federal foster care payments. The Title IV(E) ceiling was set at $349.2 million. Adoption assistance, an open-ended entitlement program, received an appropriation of $5 million, but only $442,000 was claimed by states that first year.

Many states had already begun to take legislative and administrative steps toward implementing the early intervention and permanency planning philosophy, as the drop in number of foster care cases before 1980 indicates. Thus, although no one would attribute all the changes in child welfare services since 1980 to the enactment of the Adoption Assistance and Child Welfare Act, the new legislation clearly made permanency planning a national goal and facilitated action at the state level. A comprehensive review of fiscal 1982 state child welfare program plans conducted by The Urban Institute found the requirements for receiving additional Title IV(B) monies to be a major influence on the long-range goals and objectives set by states.[6] For example, thirty-one states (60 percent) planned to develop or expand preplacement preventive services; twenty-nine states (56 percent) listed initial implementation of a foster care tracking system or modification of an existing system; and seventeen states (33 percent) proposed to begin offering or to expand reunification services.

Federal Title IV(B) expenditures represent approximately 5 percent of the total child welfare services funding in most states, and cannot be considered a significant financial resource for states.[7] Similarly, the financial incentives it offers must be considered weak given its overall impact on child welfare spending. Yet, early indications are that change has occurred not only in goals but in services. Expenditures for foster care maintenance payments and services dropped from absorbing almost three-quarters of child welfare funds (from all sources) in fiscal 1979 to less than half in fiscal 1982. Pre-

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6. In fiscal 1980, 34 percent of the primary recipients of Title XX were children (based on "Social Services U.S.A., 1979–1980," table 11, statistical tables prepared by the Department of Health and Human Services, Office of Human Development Services, 1982). Budget data from state plans show that half of the states allocated more than 46 percent of their Title XX funds to children in 1982. See Madeleine H. Kimmich, "State Child Welfare Program Plans: Service Budgets and Expenditure Reports," Contract Report (Washington, D.C: Urban Institute, August 1983).

7. Ibid.

ventive and protective services concomitantly increased their share of child welfare funds from 8 percent to a little more than 23 percent.[8]

Again, the 1980 legislation was more the culmination of state efforts and earlier federal efforts (largely through the Children's Bureau) than it was the catalyst for new state initiatives. Its funding level, even when fully funded, was not sufficient to compel states to redirect their service emphases. The legislation nonetheless was seen as significant by child welfare administrators and advocates. For some, it reinforced strong claims that change was needed and made legislative battles easier when funds were difficult to procure. For many others, the act served as a guide for designing and implementing those changes. Thus it stood as the first major federal attempt to develop and implement a national child welfare policy.

Child Welfare during the Reagan Years, 1981–84

The states entered the 1980s with a renewed commitment to bringing child welfare services in line with the growing philosophy of early prevention and permanency planning. Title XX, the major federal funding source for child welfare services, was capped (1981 federal expenditures were $2.99 billion, up only $30 million from 1978). Title IV(B) was, for the first time, fully funded with appropriations at $163.5 million (the level necessary to trigger the cap on foster care funds), up $107 million from the previous year. Even with full funding, of course, Title IV(B) could supply only a fraction of the support available from Title XX. Adoption assistance funds were available for the first time, and grants to states for child abuse and neglect reporting were holding constant at about $7 million.

The Reagan administration sought to reverse the newly implemented trends in child welfare services. It met with only partial success as the figures in table 4 show, but its intent was clear—it proposed not only to reduce funding for child welfare services but, because of less federal involvement, to make irrelevant the complex balance of protections and fiscal incentives that were built into the 1980 legislation.

Reagan's proposals for child welfare legislation followed the general philosophy of his administration: they sought to reduce the federal role and turn responsibility back to states and localities. Funding reductions in this area, as in other human services, were based on assumptions that removing one layer of government would reduce costs through better management and greater efficiency, and therefore that programs and recipients would benefit,

8. Ibid.

TABLE 4

FEDERAL OUTLAYS FOR CHILD WELFARE SERVICES, FISCAL YEARS 1981–84
(Millions of Dollars unless Otherwise Indicated)

Legislation	*1981*	*1982*	*1983*	*1984*	*Percent Change, 1981–84*	
					Current Dollars	*Constant Dollars*[a]
Title XX (social services)	2,813	2,536	2,684	2,693	−4.3	−17.6
Title IV(B) (child welfare services)	180	162	160	165	−8.3	−21.1
Title IV(E) (Foster care and adoption assistance)	328	261	410	435	32.6	14.2
Child abuse and neglect (state grants portion)	7	7	7	7	0	−13.9
Total	3,328	2,966	3,261	3,300	0.8	−14.6

SOURCE: Madeleine H. Kimmich, *America's Children: Who Cares? Growing Needs and Declining Assistance in the Reagan Era*, (Washington, D.C.: Urban Institute Press, 1985), table 3. Figures are rounded.

a. Real changes calculated by using deflator of the Office of Management and Budget (1972 base year).

or at least not suffer, from budget cuts. Reagan's budget documents retain all the pre-Reagan language describing program goals and objectives—even his proposal to convert child welfare funding to a block grant still adheres to goal statements paralleling those of the Adoption Assistance and Welfare Act of 1980. The administration made no apparent attempt to rethink or restructure child welfare services as such, other than to apply its basic strategy of defederalizing child welfare by proposing, unsuccessfully, a block grant for child welfare.

Presumably, then, the Reagan administration espoused, or at least did not specifically change or repudiate, the intent of child welfare programs to "strengthen families, prevent family break-up, and enable children to remain in their homes. In cases where children must be placed outside the home, the objective is to return these children home as soon as possible; or, when this is not possible, to secure suitable adoptive homes."[9] It is appropriate, therefore, to evaluate the administration's actions by looking at the impact on prevention, reunification, and permanency planning.

9. *Budget of the United States Government, FY 1983 Appendix* (Washington, D.C.: U.S. Government Printing Office, 1983), p. I-K59.

In both fiscal 1982 and fiscal 1983 the Reagan administration attempted to repeal the Adoption Assistance and Welfare Act. It proposed a block grant for child welfare that would combine funding for child welfare services, Title IV(B); foster care, Title IV(E); and adoption assistance, Title IV(E). Federal funds under this proposal would have been 20 percent below fiscal 1981 levels. If passed, this block grant would have removed both the financial incentives for developing alternative services to foster care and the requirements that states improve tracking, case planning, and case review capabilities in order to receive additional child welfare services funding. Also, given the 20 percent cut and the inevitable decision by states to fund crisis services first, the prevention, reunification, and adoption services would almost certainly have suffered as states attempted to meet increasing demands with fewer dollars.

Having just passed the 1980 Adoption Assistance and Welfare Act, Congress was unwilling to repeal it. The legislation remained intact, and the proposals to reduce funding by 20 percent were rejected. The foster care and adoption assistance programs were maintained as entitlements, ensuring funding for all eligible children. Child welfare Title IV(B) appropriations were cut back 4 percent from the fiscal 1981 level of $163.5 million—a significant cut given the expectation on the part of both Congress and the states that Title IV(B) appropriations would increase under the act. Authorization for fiscal 1982 was $220 million, up from $163 million in fiscal 1981.

In fiscal 1984 the administration sought to cap federal funds for foster care, Title IV(E), thereby eliminating the entitlement program that had been in effect since 1961 but without a compensatory increase in prevention, reunification, and adoption assistance. Congress rejected this proposal. The administration also sought to hold Title IV(B) at $156.3 million for the third year while eliminating $4 million available for training in fiscal 1983 through the Child Welfare Training Program. Congress raised Title IV(B) appropriations to $165 million.

As the Children's Defense Fund notes in its analysis of the 1984 budget, Congress was able to keep the legislation and most of the funding intact, but the administration was still able to undermine the 1980 act by delaying both issuance of final regulations and review of states that had self-certified that they were in compliance with the law in order to receive additional Title IV(B) funds.[10]

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10. Children's Defense Fund, *A Children's Defense Budget: An Analysis of the President's FY 1984 Budget and Children* (Washington, D.C.: CDF, 1983).

Besides attempting to dismantle the 1980 act, the Reagan administration attempted to eliminate the Child Abuse Prevention and Treatment Act in fiscal 1982. Congress rejected the proposal, but funds for the program were reduced from $23 million to $16 million. State grants for responding to abuse and neglect reports were essentially held constant at a little below $7 million. In fiscal 1983 the administration proposed a 31 percent cut in the state grant portion of the program and further proposed to merge child abuse demonstration funds with other human services research and demonstration monies. Congress rejected these proposals. The state grants were maintained at $6.7 million, and child abuse research and demonstration programs were funded at $9.5 million.

The Reagan administration was more successful at cutting and altering Title XX. As described above, Title XX was in many ways already a block grant that allowed states considerable latitude in setting service priorities and funding levels. However, the shift to a block grant (the social services block grant) did bring with it some important changes: (1) previously separate appropriations for social services, training, and child care were merged; (2) states were no longer required to match federal funds (one state dollar for every three federal dollars); and, most important, (3) states were no longer required to commit 50 percent of their funds to welfare recipients. Presumably in exchange for these relaxed requirements, funding for fiscal 1982 was 21 percent lower than that for fiscal 1981.

An additional 17 percent cut in the social services block grant was proposed for fiscal 1983. Congress rejected this proposal and maintained the block grant at its fiscal 1983 authorized level, $2.45 billion. At the beginning of fiscal 1983 the administration reduced the funding level to $2.4 billion. Congress later appropriated $225 million for Title XX social services block grant services under the Emergency Job Bill. After receiving intensive lobbying by over eighty national organizations, Congress appropriated $2.68 million for the Title XX social services block grant in fiscal 1984.

Summary

What impact has the Reagan administration had on federal funding for services for vulnerable children? Congress has been particularly aggressive in rejecting the administration's proposals to cut child welfare funding and blunt the impact of the 1980 legislation. The effect has been that federal funds for services to vulnerable children have only decreased slightly in absolute terms during the Reagan years. These decreases have been exacerbated by inflation and, more important, by increased demand for services. A survey

conducted by the National Committee for the Prevention of Child Abuse reported that thirty-nine states had seen an increase in abuse reports during 1982. Other states and localities reported that abandonment cases were up, as were requests for emergency shelter.[11] The number of children in foster care is rising across the country,[12] as the increased federal outlays for Title IV(E) foster care funds attest.

As we described in chapter 1, there is an undeniable relation between poverty and the vulnerability of children. The percentage of children living below poverty has been rising steadily since 1970 according to census data. In the single year from 1980 to 1981 this percentage jumped 1.6 percent; in the next year it rose an additional 1.8 percent, and in the following year, 0.4 percent.[13] In total there was an increase of 21 percent in children living in poverty during the first three years of the Reagan administration. Despite this trend, the administration proposed cuts not only in social services for children, but in almost every program that affects them. A separate Urban Institute book, *America's Children: Who Cares? Growing Needs and Declining Assistance in the Reagan Era*, shows this clearly.[14] Of the twenty federal programs that form the nucleus of federal support for children, only one program, Head Start, consistently received increased federal support between 1981 and 1984. Four other programs experienced net increases during that period, but their fortunes fluctuated from year to year. As we show in detail in the next chapter, these across-the-board cuts, especially in AFDC, increased the demand for all types of child welfare services at a time when states, recoiling from multilevel jolts to their budgets, could least afford to step up their response.

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11. Cited in Children's Defense Fund, *A Children's Defense Budget*.

12. Madeleine H. Kimmich, *America's Children: Who Cares? Growing Needs and Declining Assistance in the Reagan Era* (Washington, D.C.: Urban Institute Press, 1985).

13. U.S. Bureau of the Census, *Current Population Reports*, series P-60, no. 138 (1981), table 17.

14. Madeleine H. Kimmich, *America's Children*.

CHAPTER 3

WHAT HAS HAPPENED TO ABUSED, NEGLECTED, AND DEPENDENT CHILDREN?

To investigate the impact of policy changes from 1981 to 1984 on local services and children involved in the child welfare system, we visited four local jurisdictions—San Diego, Detroit, Richmond, and Boston—and spoke with public officials and private providers (see the introduction to this book for selection criteria). In this chapter we review the budget data for the local governmental units responsible for child welfare, their caseloads for selected services, and the changes that have taken place in services since 1981.

Budget Changes

Budget data were available for three of the four selected jurisdictions. Funding for child welfare services has been reduced significantly during the period of study in both San Diego and Richmond and has been increased somewhat in Massachusetts (tables 5–7). San Diego's budget cuts came largely at the county level, although federal reimbursements for intake services (child protection referral and investigation) also fell by 12 percent after adjusting for inflation. The San Diego County budget is subject to extreme constraints, not only from Proposition 13 but also from the county's own version of tax relief, Proposition J. The county contribution to the welfare of its own abused, neglected, and dependent children fell 21 percent for intake services and 30 percent for placement and supervision services, respectively, after adjusting for inflation. These cuts reflect San Diego's priorities, which do not focus heavily on children who need protection.

Richmond's child welfare services budget was also reduced, significantly for foster care services, but dramatically for child protective services (down 14 percent and 65 percent, respectively, after adjusting for inflation). Other factors that limited children's access to protective services were the increased

TABLE 5

SAN DIEGO BUDGET FOR CHILD WELFARE SERVICES, FISCAL YEARS 1981–83

	Budget for State Fiscal Year ($ Thousands)			*Percent Change, 1982–83*	
Type of Service	*1981*	*1982*	*1983*	*Current Dollars*	*Constant Dollars*
Child intake services					
Federal	n.a.	3,206	2,955	−8	−12
Title XX social services block grant	n.a.	2,472	2,868	5	0
Title IV(B)	n.a.	200	0	−100	−100
Other	n.a.	264	87	−67	−68
County	2,746	2,664	2,406	−12[a]	−21[a]
Fees and other revenue	n.a.	25	138	452	430
Total	5,899	5,895	5,499	−7[a]	−16[a]
Child placement and supervision services					
Federal	n.a.	5,893	6,630	13	8
Title XX social services block grant	n.a.	3,068	3,783	23	18
Title IV(B)	n.a.	376	0	−100	−100
Other	n.a.	2,449	2,847	16	12
County	1,901	2,456	1,463	−23[a]	−30[a]
Fees and other revenue	n.a.	1,405	965	−31	−34
Total	9,817	9,754	9,058	−8[a]	−17[a]

SOURCE: San Diego Department of Social Services budget documents. Figures are rounded.

n.a. Not available.

a. Data are for 1981 to 1983.

number of cases (which almost tripled from six to sixteen cases per month), and the drastic reduction in the average grant for purchasing child protective services (from more than $2,000 per case to about $350 per case). Richmond's child protection staff is clearly faced with doing much more with much less.

Massachusetts averted reductions in child welfare services with major infusions of state resources. The state experienced a significant drop in federal Title XX social services block-grant funding available for child welfare, even though Massachusetts devoted its entire Title XX allocation to children's services. It also received significant increases in federal child welfare payments from Title IV(B), but the total dollar amounts did not compensate for Title XX losses. Service increases approximately matched the greater amount of resources available.

TABLE 6

RICHMOND BUDGET FOR CHILD WELFARE SERVICES, FISCAL YEARS 1981–83

Type of Service	*Budget for State Fiscal Year ($ Thousands)*			*Percent Change, 1981–83*	
	1981	*1982*	*1983*	*Current Dollars*	*Constant Dollars*
Foster care					
State and federal reimbursememts	1,434	1,557	1,411	−2	−11
City	998	967	908	−9	−18
Total	2,432	2,524	2,319	−5	−14
Protective services					
State and federal reimbursements	10	6	4	−60	−64
Grants	13	8	5	−62	−65
City	3	2	1	−67	−70
Total	26	16	10	−62	−65

SOURCE: Richmond Department of Public Welfare budget data. These figures are for direct outlays for children receiving services but do not include staff salaries. Figures are rounded.

Detroit (Wayne County) could not provide budget data because, as a local office of a state agency (the Michigan Department of Social Services), it receives staffing equivalents instead of dollar figures from the state. The full-time-equivalent staffing levels in Detroit have remained relatively constant overall, although some specific services have lost heavily, as discussed below. At the same time, demand has skyrocketed for both child protection investigations and foster care placements, placing great strain on staff resources.

Caseloads

To fully appreciate the budget changes in the four jurisdictions, the dollar figures should be compared to caseload figures—what are the dollars being required to do, and do they begin to meet the need? Table 8 presents changes in child welfare caseloads between 1981 and 1983 to shed some light on this critical question. In San Diego and Richmond, the two jurisdictions with significant budget reductions for child welfare, the demand for services increased at the same time that the agencies responsible for care had fewer resources to meet the need. San Diego experienced an increase of 29 percent

TABLE 7

MASSACHUSETTS BUDGET FOR CHILD WELFARE SERVICES, FISCAL YEARS 1981–83[a]

Type of Service	Budget for State Fiscal Year ($ Thousands) 1981	1982	1983	Percent Change, 1981–83 Current Dollars	Constant Dollars
Federal	77,765	61,087	67,309	−13	−22
Title XX social services block grant	77,322	59,100	60,300	−22	−30
Title IV(B)	443	1,794	6,723	1,418	1,272
Other	...	193	286	48[b]	42[b]
State	94,935	129,413	136,691	44	30
Total	172,700	190,500	204,000	18	7

SOURCE: Massachusetts Department of Social Services. Local data for Boston were not available, but Boston receives a consistent proportional share of the state allocation. Figures are rounded.

a. Massachusetts allocated all of its social services block-grant funds to children's services beginning in 1982.

b. Data are for 1982 to 1983.

in requests for investigation of potential instances of child abuse, neglect, or dependency, in conjunction with a decrease of 16 percent in resources for the intake unit. Staff ability to respond to these requests worsened in both speed of response and numbers of cases receiving investigations. In addition, the county had to reduce slightly the number of children to whom they could offer protective supervision in their own homes (instead of removing them from their homes). It also reduced the number of children in substitute care. Overall, these figures indicate that, although the number of cases continued to grow, services did not keep pace with demand.

Richmond, like San Diego, experienced a significant increase in the number of cases receiving child protective services at the same time that staff resources and grant monies to deal with these cases were reduced.

Boston and Detroit also experienced increased demand for child welfare services, but only in Boston did the state provide the financial resources to meet the need (both states lost significant amounts of federal dollars for child welfare services). Alone among the sites, Michigan saw foster care caseloads increase despite the concerted nationwide effort to reduce the number of children in foster care, especially those receiving such care for prolonged periods. Ironically, Michigan was a leading state in promoting this nationwide effort. The increase in foster care levels in that state, therefore, attests to the

TABLE 8

CHANGES IN CHILD WELFARE CASELOADS, FISCAL YEARS 1981–83
(Average Monthly Caseloads unless Otherwise Indicated)

Jurisdiction and Service	*1981*	*1982*	*1983*	*Percent Change, 1981–83*
San Diego				
Child protective services requests	2,693	3,311	3,465	29
AFDC foster care	3,098	3,024	2,880	−7
Protective supervision in own home	1,980	2,016	1,920	−3
Detroit (Wayne County)				
Child protective services requests	7,158	8,285	12,242	71
AFDC foster care	2,265	2,934	2,867	27
Richmond				
Child protective services[a]	6	16	16	167
AFDC and non-AFDC foster care	563	563	550	−2
Boston (Region VI)[a,b]				
Child protective services	2,787	2,876	3,226	12
All foster and group care	1,877	1,630	1,601	−15
Protective supervision in own home	4,314	4,079	4,646	8

SOURCES: Department of Social Services data or personal communication from jurisdictions. Percentages are rounded.

a. Number of children, not number of requests or investigations.

b. In June of each year.

severe effects of unemployment, recession, and the accompanying strains on the ability of families to cope. Detroit has a significantly greater proportion of its children living below the poverty level than the other cities we visited—approximately 32 percent, compared to between 13 and 15 percent for the other cities. These poverty figures are for 1979, before the recession and unemployment hit other areas of the country (it was just beginning then in Detroit). In conjunction with a higher level of poverty than the other cities examined, the more extreme effects of the recession (unemployment hit 20 percent in Detroit in 1982) undoubtedly contributed to Detroit's increased need to use foster care placements.

Agency Service Structures and Populations Served[1]

In all four jurisdictions we visited, the department or division of social services has primary responsibility for child protective services and substitute care services. In two jurisdictions, Detroit and Richmond, income maintenance programs—aid to families with dependent children (AFDC), Medicaid, food stamps—operate through a separate division of the same department. In the other two cities, San Diego and Boston, a different department handles these programs. Regardless of structure, units handling the social services aspects of substitute care must coordinate with units administering AFDC, since the majority of foster care placements receive support from the AFDC-Foster Care program.

San Diego's Department of Social Services handles all child protection, emergency placement, foster care placement, and adoptions for children in the public protection system. The department's children's services are organized into two divisions, Child Intake Services and Child Placement and Supervision Services. San Diego views children's services on a continuum from intake and emergency response through preventive work with families to potential placement or adoption. The department works with both voluntary and court-ordered cases.

According to the 1980 census, children under age eighteen made up 25 percent of San Diego County's population. About 15 percent of these children live in poverty, including 18 percent of children under age five and 13.5 percent of children aged five through seventeen. San Diego's Child Intake Services registered between 18,000 and 19,000 reports of suspected child abuse, neglect, or exploitation in 1981. The data for 1982 show an increase in these reports of about 16 percent over the previous year. If we assume that each of these calls represents a different child (which probably overestimates the actual number of children by some undeterminable amount), this would mean that 4.5 percent of San Diego's 461,000 children are suspected victims of abuse, neglect, or exploitation every year. Tensions associated with economic difficulties usually exacerbate child abuse, and these figures reflect the effects of the recession on San Diego's children.

Michigan's Department of Social Services and its Wayne County office handle child welfare services similar to San Diego. In Wayne County these services are organized into three divisions: Child Protective Services, Adult and Family Services, and Foster Care and Adoption. Child Protective Services

1. Readers who are not concerned with the detailed service structures in the four jurisdictions might want to skip to the next section.

receives child abuse and neglect reports, makes investigations, and when appropriate, refers the case to the other two divisions. Adult and Family Services helps high-risk families reduce the probability of child abuse and neglect through an array of service options: in-home supportive services, day care, family counseling, employment or schooling-related counseling, and other preventive services. The Foster Care and Adoption unit receives referrals if investigation reveals that removing a child from its home is the best option for the child.

According to the 1980 census, children under age eighteen made up 30 percent of Detroit's population. About 32 percent of these children live in poverty, including 35 percent of children under age five and 30 percent of children aged five through seventeen. Making the same assumptions and calculations we did for San Diego, Detroit's 12,424 child protection investigations may affect approximately 3.5 percent of its 357,399 children under eighteen (in 1980). Since investigations (Detroit's figure) are a later stage in the process than initial requests (San Diego's figure), Detroit probably has a child abuse and neglect rate that is as high or higher than that of San Diego.

Services to children in Richmond are provided by the Department of Public Welfare through the Child Welfare Services and the Family Services divisions. Child Welfare Services includes foster care and adoptive placements, both of which receive specific federal appropriations under Title IV(E). Family Services covers a broad range of in-home supportive services for children and their families, including preventive and reunification services and day care. Federal funding comes primarily from the social services block grant; some funds also come through Title IV(B), specifically for in-home services.

The 1980 census indicates that Richmond is home to 163,793 children under eighteen, who make up 27 percent of the city's population. Approximately 14 percent of these children live in poverty, including 16 percent of children under age five and 14 percent of children aged five through seventeen. Richmond's statistics do not include the annual number of requests for child protective services, so we cannot calculate a rate for the city that would parallel the rate for San Diego and Detroit. We can, however, make some general assumptions that would permit an approximation of such a rate. Richmond has an average of sixteen child protection cases each month. If a case lasts approximately four months, one-fourth of the caseload is being replaced by new cases each month. Over twelve months, this would mean that Richmond helped an estimated sixty children in need of protective services in 1982 and 1983. If half the cases investigated result in protective services being given and half the referrals to protective services are forwarded for investigation, then the number of requests per year can be estimated at 240.

This would mean that an estimated rate of 1.5 percent of Richmond's children are becoming involved in child protective services each year—a rate far lower than that of either San Diego or Detroit.

The Massachusetts Department of Social Services delivers services to Boston's population primarily through its Region VI office. The department focuses its efforts on services to children and families. Its activities include all the child welfare services provided by our other three sites, through its Child Protection and Adoption Services units.

Census figures for 1980 indicate that Boston's 665,181 children under age eighteen make up 25 percent of its population. Thirteen percent of these children live in poverty. The rate for children under age five is 15 percent; that for children aged five through seventeen is 12 percent. Boston, like Richmond, reports only a child protective services census for a single month (June). Making the same assumptions we made for Richmond would yield an estimated 12,098 children receiving protective services each year, as a result of approximately 48,000 referrals, for an estimated rate of 7.2 percent per year involvement with child protective services in some way.

Impact of Budget and Program Changes

Child welfare services are a high priority in most states, and will usually have been protected as much as possible from absorbing the effects of federal policy changes (although some of this "protection" probably came at the expense of social services block-grant funding for employment-related child care). To some extent, however, services for abused, neglected, and dependent children felt the pinch in all four of the jurisdictions examined. Some of the strain comes from local rather than federal or state priorities, and some stems from federal policy changes in other programs (notably AFDC), which may indirectly affect the number of children in situations of high risk for abuse or neglect. In San Diego the failure to replace lost funding appears to be a combination of federal and local decisions, whereas all sources reduced spending in Richmond. In every jurisdiction except Boston, child welfare workers also cited the recession and unemployment as factors contributing to their growing numbers of abuse and neglect cases.

San Diego

Changes in funding patterns for child welfare services in San Diego, and the services themselves, have undergone great changes, but these are due at least as much to local fiscal decisions as to federal changes. Before Proposition 13 the counties paid 70 percent of foster care costs while state and federal

sources paid the rest. The 1980-81 state bailout reduced the county share to 5 percent. This bailout was slated to revert to the old ratio in January 1984, which would have left San Diego $12 million in the red if they maintained their 1983 levels of service. Since the county could not legally raise taxes (and would not if it could), the situation was potentially disastrous. However, the state renewed the bailout provisions for at least two more years, so child welfare services will not be further curtailed. San Diego County's lack of commitment to maintaining child welfare services looms even larger when one realizes that for every dollar the county fails to spend it forgoes $19 of state matching funds, yet the county has significantly reduced its child welfare budget.

With the change from Title XX to the social services block grant, California also gave the counties control over their share of Title IV(B) money for child welfare services. This has helped provide more money to San Diego because previous spending rules made it almost impossible for San Diego to spend the Title IV(B) money it nominally had available. Earlier state requirements had constrained Title IV(B) funding for use only with county recipients who were not eligible for Title XX. In San Diego there was almost no one in this category.

Child Intake Services screens potential cases; provides emergency response, short-term counseling, crisis intervention, and emergency shelter care; and has a volunteer service. This unit experienced funding reductions of 7 percent and staff reductions of 8 percent between 1981–82 and 1982–83. At the same time, initial requests for services rose 16 percent. The percentage of initial requests referred for intake screening has been dropping steadily since 1979–80. In that year 72 percent of initial calls were referred, whereas only 54 percent were referred in 1982–83. The percentage of referrals acted upon within forty-eight hours has held steady at about 30 percent, but the net effect is an approximate one-third reduction in the number of initial requests for service that receive an investigation within forty-eight hours.

Caseworkers in San Diego report having to ignore all but the most severe and immediately life-threatening situations. All over the country, child protection and mental health services staff have reported increases in battering, neglect, and other mental health consequences that they attribute to the recession and unemployment. San Diego is no exception. In addition, San Diego has worked successfully to encourage people to report child sexual abuse. Reports have jumped from 400 in 1977 to over 3,000 in 1982, but now workers have no services to offer in these cases.

Child Placement and Supervision Services, which handles foster care, adoptions, protective supervision in own homes, and licensing of out-of-home care facilities, has experienced a 17 percent drop in its budget, a 9 percent

drop in staffing, and a 5 percent drop in the average number of active cases per month. The noncounty share of this unit's budget actually increased by 4 percent between fiscal 1982 and fiscal 1983, but the county's contribution dropped by 40 percent. During 1982 and 1983, staffing levels dropped a total of 17 percent while the workload stayed approximately the same.

San Diego has reorganized both its child welfare services programs and its concept of what it is trying to do for children, largely in response to budgetary pressures. In 1982–83 San Diego put maximum effort into intensive early intervention, trying to prevent out-of-home placement where possible. During the first quarter of fiscal 1982 San Diego reduced placements by 10 percent; the staff anticipated using the $850,000 saved on placements to give intensive services to children who had only recently been removed from their homes. In this way the staff hoped to help those already removed from their homes to get back to their families. Their theory was (and is) that short-run intensive services save long-run foster care costs. It is unfortunate that the county's fiscal situation is so bad and its priorities are so different from child welfare that the county took back the $850,000 and reassigned it to public safety uses. This left the child welfare staff completely demoralized.

In addition to San Diego's child welfare services budget of $14,557,000, the AFDC foster care program supported children in foster care at a cost of $17,949,813 in fiscal 1982.

The staff voiced numerous complaints about the irrationality of some recent changes in their service and reporting obligations. One of these was due to the Adoption Assistance and Child Welfare Act of 1980, compounded by state actions. The California legislature complied with this legislation by ordering reviews of children in placement every six months. At the same time it reduced required reviews of adult cases from every six months to annual reviews. Reasoning that one change offset the other, the state legislature failed to appropriate any more money for the paperwork required in case reviews for children. The San Diego Social Services Department staff does not find these changes an even trade. Child welfare caseworkers are spending significantly more time on paperwork and less on casework, according to their perceptions. All felt the federal legislation makes sense but cannot be translated into the services intended if it is seriously underfunded.

Finally, caps on funding available to provide child care for children in potentially abusive families, instituted by new regulations for Title IV(A), social services block grants, and AFDC, are viewed as counterproductive for families who become child protection cases. Resources in these families are so low that children are often left alone. The staff believes there is more neglect and abuse as more pressures are loaded on parents whose performance is already marginal. More child care funding would enable parents to leave

their children under adequate supervision while working, looking for work, or receiving employment training. In these matters the San Diego staff's feelings mirror perceptions nationwide, that the array of federal resources withdrawn from poor and near-poor families, coupled with the pressures of the recession, increase the likelihood of child abuse and neglect.

Detroit

Child welfare services have long been a high priority in Michigan. When Michigan began experiencing recession in 1978 and the Department of Social Services faced reductions in services and staff positions, children's services were cut only 8 percent while all other programs lost 20 percent of their support. The federal cutbacks exacerbated the already existing strains on the state budget. In fiscal 1982 the department made large layoffs in assistance payments workers and services workers. Child Protective Services was perhaps the hardest hit because many of the workers were new (due to high turnover and some new positions) and they had little seniority. Adult and Family Services workers were also initially slated for cuts, but the department redefined family services to be preventive services for high-risk clients and hence was able to cover personnel costs with the new Title IV(B) monies.

As unemployment rises and AFDC, Medicaid, and general assistance benefits decline, families are known to be under greater stress and the incidence of child abuse and neglect appears to increase. As table 8 shows, protective services requests for Wayne County rose markedly between fiscal years 1981 and 1982. However, substantiations dropped, both absolutely (down 9 percent) and as a proportion of requests (down from 86 percent to 67 percent). Detroit child welfare officials offer several possible explanations: public awareness has grown, hence they receive more requests for less serious problems; or the staff is overworked and takes less time to thoroughly investigate the cases. The Department of Social Services staff suspects the latter is closer to the truth; protective services in Wayne County has lost staff and gained cases to the point that the staff acknowledges they do less intense follow-through across the board. Improvements were presumably at hand—protective services statewide was slated to receive 100 staff positions and $2 million from a 1983 tax increase. However, state-level protective services staff reports that it has not received staff increases to date, even though the tax increase passed. The staff reports that it continues to have far too few staff members for the ever-growing number of cases.

With the loss of Title XX funds in fiscal 1981, the Department of Social Services transformed the Family Support Services program into the Preventive Child Abuse and Neglect Services program, which could then be supported

with Title IV(B) monies under the Adoption Assistance and Child Welfare Act. The shift nonetheless meant a major reduction in staffing statewide. Wayne County services remained fairly stable, but far below the level needed to implement any new service programs (as originally planned under the act). Preventive Services receives its cases by referral from Protective Services; thus the primary focus is on families at high risk of child abuse or neglect.

In fiscal 1982 the state took several actions affecting foster care. First, it froze rates for foster care providers. Second, the state legislature passed a law requiring the Department of Social Services to reduce from 24 percent to 18 percent the proportion of its nonadoptive preadolescent child population that was in residential care. The burden of this reduction fell on Wayne County, where all but ten of the ninety-seven children in residential institutions live. Third, Michigan capped the amount it would spend for AFDC-eligible foster care children, thus passing the financial burden on to the counties.

Between fiscal years 1981 and 1982 the Department of Social Services lost substantial funding for foster care services, which exacerbated the effects of its funding cutbacks in the social services block grant, Title XX. Title IV(B) fell from $6.2 million to $5.9 million, and the new Title IV(E) foster care reimbursements fell from $21.7 million to $15.2 million. AFDC-Foster Care placements rose by about 30 percent during this time (see table 8), adding greater demands on both county budgets (to match the federal AFDC-Foster Care payments) and on local staff to find suitable placements. Reductions in Medicaid coverage added another complication to the difficulties of recruiting foster homes. Foster families' unhappiness with the frozen rates was increased because they had to pay for children's eyeglasses and prescriptions.

Group homes face a different problem. Reductions in coverage for mental health services have led to diagnosing more children with "character disorders" as victims of abuse or neglect so that Title IV(B) can be used to pay for the services they need. These children are being placed in group homes, which are not equipped to handle the problems the children present. Placement of these children in group homes puts unnecessary strain on staff and, equally important, fills foster care slots that are needed for other children.

Michigan has a strong adoption subsidy program. Statewide, the number of adoptive placements has been increasing, as has the number of special needs placements. Adoptive placements rose 32 percent between fiscal years 1979 and 1982. Placement of minority children and handicapped children rose 59 percent and 32 percent, respectively, during the same period. Subsidized adoptions, an important emphasis of the Adoption Assistance and Child Welfare Act, rose 122 percent. Nonetheless, Wayne County faces a serious problem of understaffing that restricts its ability to proceed with adoption plans for all appropriate children. At public hearings held in Detroit

in May 1983, participants testified that in Wayne County alone 250 children await adoptive placement.

The overall picture in Detroit is one of increasing demand for services, staff and service cuts, and less optimal care for children in need.

Richmond

The significant changes made by the Reagan administration in many human service programs directly or indirectly affect children served by the Richmond Department of Public Welfare. The program area with the most easily identifiable impact on children is social services, which is primarily funded by the social services block grant. Title IV(B) and Title IV(E) of the Social Security Act also support child welfare services, although funding levels are low compared to social services block-grant dollars going for the same services. The city absorbed a decrease of 19 percent in social services block-grant monies between fiscal years 1981 and 1982; for child welfare services, this has meant both drastic cutbacks in the purchase of services and increased caseloads for direct service staff.

The Child Welfare Services division has maintained fairly steady budget and staffing levels since 1980–81, largely because of open-ended federal support. Title IV(E)and Title IV(A) foster care had a federal ceiling in 1981, but Virginia was not affected. Foster care caseloads have been decreasing, f om an average of 563 cases per month in 1980–81 to 520 currently. There were 1,153 children in foster care on December 31, 1980; two years later, there were 942, a drop of 18 percent. The average age of children in care has decreased, from age seven to age five, and the average length of stay is also shorter. Nearly half of all foster care children are returned home within ninety days (perhaps partly due to the state's ninety-day limit on entrustment, or voluntary, placements). These reductions in foster care cases reflect the nationwide push to reduce the number of children in foster care.

Adoption services similarly have fared well in recent years. With the start of open-ended federal adoption assistance in 1981, Richmond benefited from federal sharing in what was previously a state-local subsidy program. In 1980, the Child Welfare Services division placed thirty-four children in adoptive homes; in 1981, thirty-seven children; and in 1982, twenty-eight children. Of adoptive homes, 40–60 percent receive adoption subsidies.

While out-of-home services to children in Richmond were largely untouched by federal cutbacks because of new Title IV(E) funds, the situation is dramatically different for in-home services. The Family Services division had a staff of 157 in January 1982; one year later, the staff numbered 70. The budget similarly dropped drastically, from over $1 million in fiscal 1982

to $374,000 in fiscal 1983. The cuts came chiefly at the expense of the non-AFDC population; all the day care and education and training services were eliminated for income eligibles (those whose income qualified them for services but who did not receive AFDC). More recently, day care has been additionally cut back to exclude all former AFDC recipients.

The impact on both recipients and service providers has been substantial. Day care is now available only for AFDC families in which the parent is working or in training (but those training and placement services have been drastically reduced). The staff providing services reports many former AFDC recipients returning to the rolls. The combination of day care cuts, Medicaid changes, and food stamp reductions have posed critical problems for many families. Families are entering with more serious problems than previously. Family Services currently has three protective services units, handling 260 cases. In addition, two intensive services units work with 144 cases in which there is a high risk of child maltreatment or other crisis. Family Services is also pioneering a project in structured family therapy, aimed at returning foster children to their natural families.

As the demand for crisis intervention has increased, Family Services workers have become less able to deliver noncrisis preventive and supportive services to intact families. It is paradoxical that the Adoptive Assistance and Child Welfare Act encourages preventive service to children at the same time that cutbacks in general social service funds force states to focus on crisis intervention. Social services department managers and supervisors express much frustration with state and federal "prevention policy" that is not backed up by adequate funds to enable agencies to move beyond the emergency needs of families. Prevention remains largely a luxury.

Boston

The budget for the Massachusetts Department of Social Services has grown slightly in recent years, which is surprising in light of the cutback in social services block-grant funds. Children and family services are a high priority in Massachusetts. When the Department of Social Services faced a loss of nearly $20 million in federal social services funds, the legislature was prepared to fill the gap. The governor objected to a short-term solution that would heavily tax other state activities, so the Department of Social Services, the legislature, and the governor together worked out a compromise whereby the department would absorb half the cuts ($10 million) in state fiscal 1982, but would not have to absorb cuts in subsequent years. At the same time, Massachusetts received increased funding from Title IV(B), legislated by the Adoption Assistance and Child Welfare Act, so the social services budget

actually increased from its 1981 level. This pattern is projected to continue throughout state fiscal 1984.

State officials say the $10 million loss in social services block-grant funds was absorbed through reductions in out-of-home care, both foster family and group care. Statewide caseloads dropped 10 percent between June 1981 and June 1982, and another 3 percent the following year (see table 12). The decline was even greater in the Boston region—15 percent over the two-year period. The social services staff there reports that the focus was on reducing the number of children in group care, but the figures belie that assertion. Foster family care in Boston decreased at four times the rate of group care.

While substitute care caseloads did drop during fiscal years 1982 and 1983, state officials now feel that the projected cutbacks were overly optimistic. Placements are reportedly rising again, especially for group care. Funds are becoming tight because the anticipated decrease in placements was budgeted into state fiscal 1984. There may have been programmatic side effects as well. To achieve the cost savings, it became more difficult to get children into substitute care, perhaps putting added stress on many families and increasing the likelihood of abuse.

Massachusetts apparently has not significantly increased its subsidized adoptions since 1981. Data are incomplete, but the state as a whole had forty-one subsidized adoptions in 1982 and only twenty-four in 1983. No data are available for the state or for the Boston area on unsubsidized adoptions. This rate of subsidized adoptions is extremely low. Michigan, with approximately 65 percent of Massachusetts' population, placed sixteen times the number of children in subsidized adoptions in 1982 (663 versus 41). Given the low level of Massachusetts' adoption activity, it seems unwarranted to place too much emphasis on fluctuating numbers.

The staffs at both state and local levels note a significant increase in abuse and neglect referrals. This may be due to the cutbacks in income assistance and service programs or due to the greater visibility of the Department of Social Services (it is a fairly new agency, previously part of the Department of Public Welfare).

Whatever the cause, staff members are facing increasing demand for services in this area. Neighborhood Health Centers staff also see increased need for child protective services and mental health counseling; they note greater difficulty in making referrals to the local Department of Social Services agency, presumably because that agency's staff is overloaded.

Summary

Assessing the impact of federal changes on child welfare services is complicated by the contradictory thrusts of the Adoption Assistance and Child

Welfare Act (pre-Reagan administration) and the Reagan administration's underfunding of its provisions. The act emphasizes preventive, supportive, and reunification services and permanency planning, and the Reagan administration continues to endorse these program goals. Several of the states and jurisdictions visited during the preparation of this study were moving in these directions even before this legislation passed in the last days of the Carter administration. With full funding for its provisions, one would have expected to see reduced foster care placements, reductions of average time in foster care; increased permanency planning, adoptions, and subsidized adoptions; and increased in-home supportive services for high-risk families. The preventive, reunification and adoption assistance services that would have increased with appropriate funding levels would have helped families avoid removal of a child, helped children return to their natural families, or increased adoptions. All these activities either remove children from foster care or prevent their initial entry into the system, hence the projected reductions in the foster care rolls.

Foster care cases have indeed been reduced in three of the four jurisdictions included in this study at the same time that child protection requests, referrals, investigations, and services increased, often dramatically, in all jurisdictions. It is impossible to sort out how much of the foster care reductions stem from a concerted programmatic effort to reduce this type of care and how much they have occurred because reduced staff have been overwhelmed by the increased child protection work. If a clear pattern could be documented showing an increase in in-home protective services, coupled with a reduction in foster care placements, the progammatic explanation would be strengthened. The available data do not allow us to make this case, however. In San Diego both foster care services and in-home protective services show decreases during the years under investigation, while Boston's figures indicate that in-home protective services rose as foster care caseloads fell (see table 7). The other two jurisdictions do not report their service data in a way that permits a comparison to be made.

All these factors lead one to think that reductions in foster care rates reflect jurisdictions' efforts to implement the philosophy of the Adoption Assistance and Child Welfare Act, complicated by their budgetary and staffing difficulties. In all jurisdictions the staffs commented that they agreed with the federal emphasis on reducing substitute care placements, doing more permanency planning, and making greater efforts to strengthen families so that children did not have to be removed from their homes. Many also commented that budget cutbacks had made it very difficult for them to implement this approach and that the federal incentive system (the combination of mandates of the Adoption Assistance and Child Welfare Act and Reagan admin-

istration funding patterns) was self-contradictory. Cutting funds for child welfare services (prevention, reunification, and adoption assistance) and child protective services covered by the reduced social services block grant could only lead, in their opinion, to more foster care placements, longer lengths of stay for children placed in substitute care, and more children at risk who receive no services. When money is available for foster care but not for prevention, in the long run more cases will be resolved by out-of-home placement than by family support services.

The significant increases in child protective services in all jurisdictions very possibly reflect additional contradictions in and ramifications of the patterns of federal cutbacks. In all jurisdictions many families have lost AFDC benefits as a result of federal program changes. All jurisdictions have experienced significant cutbacks in funding for day care through (1) the social services block grant (Title XX) cuts, (2) changed priorities for spending the remaining dollars, (3) reduced per-person allowable costs, and (4) switching from Title XX to a Title IV(A) disregard as a source of day care funding (which means much less money available for each day of child care).[2]

It is also likely that the change in foster care policy itself increased child protection cases. Decisions to leave children at "less severe" risk of abuse in their homes, when they would previously have been removed, probably expose these children to continued and possibly increased risk. Child protective services staff in all jurisdictions mentioned these changes and viewed them as putting increased pressures on families whose economic and interpersonal or parental viability was marginal. The social services staff believes these pressures and strains are probably responsible, along with general economic hard times in most of the jurisdictions, for the increased amount of child abuse and neglect being reported in all the cities studied here.

By reducing funding for all child welfare services beyond the capacity or willingness of many jurisdictions to compensate, federal changes during the Reagan administration have increased the risk of severe harm to children through parental abuse or neglect. Pressures on local agencies to avoid removing children from their homes, coupled with increased abuse and neglect reporting and decreased agency resources for intervention, appear to have left more children in high-risk situations without the protection of preventive or ameliorative services. As a result of budget cuts, staff reductions, or increased service demand, the remaining staff members report doing less thorough investigations of reports and selecting only the life-threatening cases for in-

2. Specifically, this disregard is a provision that allows AFDC recipients to spend some earned money on day care without having it reduce their AFDC eligibility or grant amount.

vestigation and services where previously they would have intervened in less severe (but still harmful) cases. There is little doubt that federal changes have reduced the ability of child protection workers in local jurisdictions to serve children at levels prevailing before the cuts in the social services block grant and other changes occurred in federal policy.

PART TWO

THE CHRONICALLY MENTALLY ILL

CHAPTER 4

WHO ARE THE CHRONICALLY MENTALLY ILL?

Changes in federal programs and benefits have significantly affected the structure of services for the chronically mentally ill during the last two decades. Beginning in 1963, the federal government undertook financing for the development of community mental health centers. The impetus behind developing these centers was an intention to prevent admissions and readmissions to public mental hospitals and reduce long-term stays by providing more mental health services in the community.

In 1965, Medicaid (Title XIX of the Social Security Act) began to pay for long-term nursing home care for indigents, and many states transferred geriatric and other patients from mental hospitals into nursing homes to shift the cost burden at least partially to the federal government. Supplemental Security Income (Title XVI of the Social Security Act) became available in 1974, providing cash income at a minimum living standard to persons unable to work. Many chronically mentally ill qualified for this assistance but could only receive it if they resided in the community, not in a mental hospital. Supplemental Security Income (SSI) payments made it even more attractive for states to discharge patients from mental hospitals and thereby increase the numbers of chronically mentally ill living in the community.

By 1980 Congress and the Carter administration had taken a long look at federal involvement with the chronically mentally ill. It appeared that community mental health centers, the federal program initially intended to focus directly on the chronically mentally ill, were not doing enough for this population. The Mental Health Systems Act, passed in October 1980, refocused efforts specifically on the chronically mentally ill.

Legislative and adminstrative changes under President Reagan came swiftly. The Omnibus Budget Reconciliation Act of 1981 repealed all important programmatic changes of the Mental Health Systems Act and appropriated a

reduced amount of federal funding for mental health into a block grant to the states (the alcohol, drug abuse, and mental health block grant). At the same time the Social Security Administration began more frequent and more stringent reviews of applications from new and continuing recipients of SSI payments, with serious results for many chronically mentally ill SSI recipients.

The history of federal policy addressing this population and the changes that have occurred under the Reagan administration, as well as the clearly vulnerable nature of the chronically mentally ill, led us to select this group as one of the three needy populations in this study.

The Chronically Mentally Ill Population Defined

One of the hallmarks of a vulnerable group is the inability of its members to take care of their own most basic needs. The stereotypical image of the chronically mentally ill is of people so out of touch with other people, and so incapable of functioning in the world of work and family, that they must be hospitalized for their own protection, usually for a long time. The actual state of these chronically mentally ill people has changed somewhat over the last quarter century, both in their place of residence and in the ability of some of them to function. A large proportion of chronically mentally ill persons who once resided in state and county mental hospitals now live in the community, where they may receive supportive services. However, many thousands do not receive such services.

Chronically mentally ill persons, by reason of their mental disorder, usually need help with very basic things: taking medications regularly, grooming and dressing, feeding themselves regularly and nutritiously, and finding adequate and safe housing. Very often they have no family on which to rely, no friends, and no associations with other community members. Typically they have poor job histories or have never worked, have few skills, and lack the concentration necessary to do even the simplest jobs in most work settings. Finally, they may lose their mental or emotional stability in response to stress in their lives, and behave in ways that disturb others enough to become hospitalized, sometimes for long periods of time.

Despite the potential functional limitations of the chronically mentally ill, most practitioners now recognize that many of these persons can be helped to achieve a range of functional abilities, including living in the community, partially supporting themselves, and relying less on repeated hospitalizations. Social supports and services provided from a rehabilitative perspective can assist members of this population to live more independent lives, as evidence cited below indicates.

The National Institute of Mental Health uses three components in its definition of chronic mental illness: diagnosis, disability, and duration.

Diagnosis—To be considered chronically mentally ill, a person must first meet the criterion of diagnosis—does the person have a severe mental condition? Diagnoses most common among the chronically mentally ill are the psychoses (schizophrenia, depression and manic-depressive disorders, paranoid and other psychoses, and organic brain syndrome). Other diagnoses include some severe personality disorders (for example, "borderline disorders") and nonpsychotic organic brain syndrome (senility without psychosis). Current estimates indicate that approximately 3 million adults meet the diagnosis criterion at any given time in the United States.[1]

Disability—Not everyone with a diagnosis of severe mental disorder suffers a significant amount of disability. Disability refers to functional impairment—that is, the inability to carry on major life activities. Inability to work, to keep house, and to look after children are obvious functional impairments arising from mental illness. Other impairments include self-care, communication with others, learning, ability to get around by oneself, and the ability to make daily and more long-term decisions. Although functional impairment may be difficult to measure precisely, disability remains a necessary component of the definition of chronic mental illness. The National Institute of Mental Health estimates that of the 3 million people with diagnoses of severe mental disorder, 2.4 million, or 80 percent, suffer moderate to severe disability caused or exacerbated by their mental condition.

Duration—The final criterion in defining the chronically mentally ill is duration. Usually twelve months is the shortest period of disability that justifies the designation of "chronic." The National Institute of Mental Health estimates that of the 2.4 million people experiencing moderate to severe disability arising from severe mental disorder, 1.7 million maintain this condition for at least one year. This is 57 percent of those with severe disability due to a mental disorder. It also represents approximately 1 percent of the U.S. adult population.

Combining the definitional components of diagnosis, disability, and duration, the National Institute of Mental Health developed the following definition of the chronically mentally ill population.[2]

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1. The estimates of the chronically mentally ill in this section are based on U.S. Department of Health and Human Services, Steering Committee on the Chronically Mentally Ill, *Toward a National Plan for the Chronically Mentally Ill*, Report to the Secretary, publication (ADM) 81-1077 (Washington, D.C.: U.S. Department of Health and Human Services, December 1980), pp. 2-1, 2-17 to 2-20.

2. Ibid., p. 2-11.

The chronically mentally ill population encompasses persons who suffer certain mental or emotional disorders (organic brain syndrome, schizophrenia, recurrent depressive and manic-depressive disorders, paranoid and other psychoses, plus other disorders that may become chronic) that erode or prevent the development of their functional capacities in relation to (three or more of) such primary aspects of daily life as personal hygiene and self-care, self-direction, interpersonal relationships, social transactions, learning, and recreation, and that erode or prevent the development of their economic self-sufficiency. Most such individuals have required institutional care of extended duration, including intermediate-term hospitalization (ninety days to one year in a single year), long-term hospitalization (one year or longer in the preceding five years), or nursing home placement on account of a diagnosed mental condition or a diagnosis of senility without psychosis. Some such individuals have required repeated short-term hospitalization (less than ninety days), have received treatment from a medical or mental health professional solely on an outpatient basis, or—despite their needs—have received no treatment in the professional-care service system. Thus, included in the population are persons who are or were formerly "residents" of institutions (public and private psychiatric hospitals and nursing homes), and persons who are at high risk of institutionalization because of persistent mental disability.

Characteristics of the Population

The standard demographic characteristics of the chronically mentally ill differ substantially from those of the nondisabled population of the United States. Estimates come from the 1978 Survey of Disability and Work, conducted by the U.S. Bureau of the Census, and from data collected on clients of a special program designed to serve the chronically mentally ill—the Community Support Program. The demographic data from the Survey of Disability and Work for the chronically mentally ill describe only those persons residing in households, either with family members or by themselves. The majority of persons described in the data from the Community Support Program also reside in the community (91 percent). These statistics for the chronically mentally ill do not include patients under long-term residential care, either in mental health facilities or nursing homes. Table 9 presents data by sex, age, marital status, race, and earnings for persons aged eighteen to sixty-four in 1978 who were residing in households (not institutions or other group living quarters) and data on the chronically mentally ill who participated in the Community Support Program in 1980.

The chronically mentally ill residing in U.S. households are more often female, middle aged or older, and less often married than their nondisabled counterparts. They are also more often female, older, and married than Community Support Program participants. The biggest difference observable in table 10 lies in the earnings data. Persons participating in Community Support Programs had median incomes of $3,900 in 1980, compared to the median

TABLE 9

DEMOGRAPHIC CHARACTERISTICS OF THE CHRONICALLY MENTALLY ILL AND PERSONS WITHOUT DISABILITIES, 1978 AND 1980
(Percent unless Otherwise Indicated)

Characteristic	*Persons Aged 18 to 64 Residing in Households, 1978*		*Percent of Participants in Community Support Programs, 1980, Who Are:*[b]
	Percent of Persons with No Mental or Other Disabilities Who Are:	*Percent of Persons with Chronic Mental Illness Who Are:*[a]	
Male	50	37	47
Female	50	63	53
Age 20 to 34	47	21	43
Age 35 to 64	53	79	57
Married	72	59	11
Separated, divorced, or widowed	10	27	33
Never married	18	13	56
White	90	87	91
Black	10	13	9
Median income (dollars)	17,710	. . .	3,900
Unable to work	7	50[c]	75

SOURCES: Persons aged 18 to 64—John W. Ashbaugh et al., "Estimates of the Size and Selected Characteristics of the Adult Chronically Mentally Ill Population Living in U.S. Households," *Research in Community and Mental Health*, vol. 3 (1984), pp. 3–24; percent participating in community support programs—Ingrid D. Goldstrom and Ronald W. Manderscheid, "The Chronically Mentally Ill: A Descriptive Analysis from the Uniform Client Data Instrument" (Rockville, Maryland: National Institute of Mental Health, Division of Biometry and Epidemiology, 1981); median income of persons without mental or other disabilities—median household income for 1980, based on U.S. Bureau of the Census, *Statistical Abstract of the United States* (U.S. Government Printing Office, 1984), table 755; unemployment data for persons aged 18 to 64—ibid., table 755, rate for 1980. Figures are rounded.

a. Totally or partially disabled for at least twelve months.

b. Many states offer a Community Support Program to enable the chronically mentally ill to remain in the community.

c. See text for explanation.

income of U.S. households of $17,710. Seventy-five percent of those in a Community Support Program were not in the work force due to disability and 50 percent of them received income from government income support programs (Supplemental Security Income). These figures can be compared to a national unemployment rate in 1980 of 7 percent among nondisabled persons, and an estimated 16 percent in 1978[3] for persons aged eighteen to sixty-four residing in households who were unable to work due to disabling conditions other than chronic mental illness. Persons identified in the Survey of Disability and Work as "disabled due to chronic mental illness" had, by definition, either total or partial work disability. Other research (see table 10) suggests that approximately half are severely disabled (unable to work at all) and half are partially or moderately disabled (able to work less and at less demanding tasks). This would put the "unable to work" rate in the second column of table 10 at 50 percent or higher. These data on earnings and nonparticipation in the labor force for the chronically mentally ill clearly indicate their disabled and vulnerable status and their need for assistance.

Changes in Living Arrangements

Over the past three decades the most dramatic change in the situation of the chronically mentally ill has been in place of residence. In 1955 almost 80 percent of the chronically mentally ill occupied beds on a long-term basis in state and county mental hospitals. Such inpatient status accounted for 559,000 beds in that year, virtually all of which were occupied by long-term residents. The years have seen an accelerating shift away from inpatient care, to 504,000 in 1963, 216,000 in 1974, and 150,000 beds in 1980.[4] A shift toward shorter and more frequent hospitalizations has also occurred. Although the daily census in inpatient mental health facilities averaged 150,000 in 1980, there were more than 650,000 readmissions to such facilities in the course of a year.[5]

Institutions

While mental health facilities (state and county hospitals, Veterans' Administration inpatient facilities, private psychiatric hospitals, residential treatment centers, and community mental health centers' inpatient facilities) have

3. John W. Ashbaugh, et al., "Estimates of the Size and Selected Characteristics of the Adult Chronically Mentally Ill Population Living in U.S. Households," *Research in Community and Mental Health*, vol. 3 (1984), pp. 3–24.

4. Ibid., p. 1–2.

5. Ibid., pp. 2–12.

TABLE 10

LIVING ARRANGEMENTS OF THE CHRONICALLY MENTALLY ILL, LATE 1970s

Type of care	*Number (Thousands)*[a]
Community	
Board and care facilities	300–400
Persons aged 18–64 residing in households	
Severe disability	530
Moderate and severe disability	1,000
Subtotal	830–1,400
Institutions	
Mental health facilities	150
Nursing homes	
Severe mental disorders	350
Senility but no psychosis	400
Subtotal	900
Total	1,730–2,300

SOURCES: For persons in institutions, mental health facilities—includes residents for 1 year or more in state and county hospitals, Veterans' Administration inpatient facilities, private psychiatric hospitals, residential treatment centers, and community mental health centers, based on estimates provided by the Division of Biometry and Epidemiology, National Institute of Mental Health, 1975; nursing homes—based on 1.3 million residents of skilled nursing and intermediate care facilities sampled by the National Center for Health Statistics, National Nursing Home Survey, 1977; residents with mental disorders—persons with a diagnosis (primary or nonprimary) from Section V of the International Classification of Diseases-9, National Nursing Home Survey, 1977; and residents with senility but without psychosis—persons with a diagnosed condition (primary or nonprimary) coded 797 in the International Classification of Diseases-9, National Nursing Home Survey, 1977. Figures are rounded.

For persons in communities, board and care facilities—based on Department of Health and Human Services, Public Health Services, Steering Committee on the Chronically Mentally Ill, *Toward a National Plan for the Chronically Mentally Ill*, Report to the Secretary, publication (ADM) 81-1077 (Washington, D.C.: DHHS-PHS, December 1980), p. 2-20; households, persons aged 18–64—based on John W. Ashbaugh et al., "Estimates of the Size and Selected Characteristics of the Adult Chronically Ill Population Living in Households," *Research in Community and Mental Health*, vol. 3 (1983), pp. 3–24; severe disability—includes persons with a mental disorder who are unable to work for one year and those who could work only occasionally or irregularly, estimates of proportions derived from proportion severely disabled and proportion partially disabled as reported in Ashbaugh et al., ibid., multiplied by the respective proportions found in The Urban Institute, Comprehensive Needs Survey, 1973; and moderate disability—includes so-called "partially disabled" persons whose work, including housework, was limited by a mental disorder, estimates of proportions derived from The Urban Institute, Comprehensive Needs Survey, 1973, and applied to Ashbaugh et al., "Estimates of the Size and Selected Characteristics."

a. For community population, upper and lower bounds of estimates; for institutional population, number of occupied beds.

registered a dramatic drop in daily census in recent years, many of the chronically mentally ill who once resided in such facilities have not returned to community living. Rather, many of them have simply been moved from one institution to another. The nursing home population expanded greatly during the same years that the mental health facility census dropped, and a large number of nursing home beds are now occupied by people who would earlier have been placed in mental health facilities.

Table 10 shows the current best estimates of the residential location of the chronically mentally ill. In 1977 a total of 1.3 million people lived in skilled nursing and intermediate care facilities. Of these, 350,000 (27 percent) had a diagnosis of severe mental disorder and an additional 400,000 (31 percent) had a diagnosis of senility without psychosis (these people are included in our calculations because they were once housed in mental health facility geriatric units). For all practical purposes, nursing home residents with mental illness diagnoses can be considered just as "institutionalized" as if they were in state or county mental hospitals. In fact, they often receive fewer or no services directly relevant to their mental disorder in nursing homes than they would in mental health facilities, and they are otherwise equally regimented. They are therefore grouped under the category "Institutions" in table 10.

The Community

Since the number of chronically mentally ill persons, as a proportion of the adult population, has remained quite constant during the time that mental health facilities were reducing their inpatient capacity, the number of chronically mentally ill living in residential arrangements other than mental health facilities increased as the hospitalized population shrank. Estimates of the chronically mentally ill population living in a variety of community residential settings indicate that this population equals or exceeds the population in institutions, both in hospitals and in nursing homes (table 10).

Between 300,000 and 400,000 persons with chronic mental illness live in board and care facilities. These facilities have many names—board and care, foster care, group foster care, domiciliary care, residential care, personal care homes, group homes, and congregate facilities. Many such facilities offer only room and board as required services. Some, known as SROs (for single-room-occupancy hotels) offer only lodging. Some, but by no means the majority, offer residents some personal supervision, possibly in the areas of managing their medications or finances.[6]

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6. Kenneth J. Reichstein and Linda Bergofsky, *Summary and Report of the National Survey of State Administered Domociliary Care Programs in the Fifty States and the District of Columbia* (Dedham, Massachusetts: Horizon House Institute, December 1980).

A study published in 1983 has produced estimates of the number of chronically mentally ill in households—that is, persons who live with family members or by themselves but do not live in group quarters or institutions—based on national samples of U.S. households and not on samples of service agency clients.[7] These estimates offer a more accurate reading of the total chronically mentally ill population than has previously been available. As table 10 indicates, approximately one million adults between the ages of eighteen and sixty-four are chronically mentally ill and living in households at any given time. This figure includes people who are severely disabled and those who are moderately or partially disabled.

Since the data in table 10 come from different sources and cover different components of the population, adding the numbers to obtain a total figure is risky. Nevertheless, the number of chronically mentally ill in the community appears to be between 800,000 and 900,000 individuals with severe disability, and 1.3 to 1.4 million with severe and moderate disability. When these numbers are combined with the 900,000 in institutions, the estimates yield numbers that quite closely approximate those in estimates of the U.S. Department of Health and Human Services.[8]

The Special Needs of the Chronically Mentally Ill

The shift in the location of the chronically mentally ill population, from the back wards of state mental hospitals to other residential settings, has evolved as a consequence of several factors acting concurrently. First, the availability of psychotropic drugs, which appeared in the early 1950s, made it possible to reduce disturbing psychiatric symptoms to the level of community acceptance for many chronically mentally ill persons. Second, a therapeutic ideology and social movement developed within the mental health community that condemned the dehumanizing effects of long-term institutionalization. This movement emphasized treatment and rehabilitation for people with mental illness rather than custodial care. It also argued that with appropriate supportive services, most mental patients did not have to live in large institutional settings. Instead, they could be more appropriately and more humanely cared for in the community.

Although therapeutic innovations and arguments did play important roles in promoting deinstitutionalization, an even stronger impetus was financial. States could save considerable amounts of money by closing state hospital

7. Ashbaugh et al., "Estimates of the Size and Selected Characteristics of the Adult Chronically Mentally Ill Population Living in Households," pp. 3–24.

8. U.S. Department of Health and Human Services, *Toward a National Plan*.

wards and returning mental patients "to the community." Some of these savings came about because the burden of financial support could be shifted from state to federal programs, but some of the savings occurred for the very simple reason that the former patients received less care and support in the community than they had in the hospital. According to numerous research studies, in many instances released patients received no care or supportive services once they left the hospital.

Bachrach, summarizing and analyzing twenty years of research on deinstitutionalization, attributes many of the flaws in the concept to the failure to recognize the many different functions once performed by state mental hospitals.[9] State mental hospitals served largely custodial functions, but they did successfully fulfill these functions, whereas many of them go unfulfilled when mental patients are released to or remain in the community. Housing, food, clothing, hygiene, and physical health needs were all attended to, the hospital provided a continuum of wards to shelter patients with more and less extreme symptoms, and the hospital could serve as a retreat for persons who had trouble coping with daily life. No coordination among agencies or services was needed because the hospital staff oversaw all activities that occurred on the hospital grounds. Patients did not need to know how to manage their money, how to use the public transportation system, or how to contact government agencies because none of these were relevant to their lives as patients. They did not receive much, if any, treatment in a mental health sense, nor were they "rehabilitated" to enable them to return to productive community lives. But they usually did receive the maintenance or custodial aspects of care.

The greatest criticism of the deinstitutionalization movement is that it has left too many former patients with no system of care at all. Elderly patients, and many nonelderly as well, have been shifted or diverted from state hospitals to nursing homes. In nursing homes they continue to receive the custodial aspects of care, but receive no more and usually less therapeutic intervention for their mental illness than they did in state hospitals. For states, the big benefit of nursing home care is that the federal government picks up a good share of the cost through Medicaid.

Many people who would formerly have entered state hospitals now reside in board and care facilities or single-room occupancy hotels. These facilities are often referred to in the literature as "psychiatric ghettos" because their residents are largely former mental patients who receive little or nothing

9. Leona L. Bachrach, *Deinstitutionalization: An Analytical Review and Sociological Perspective*, U.S. Department of Health, Education, and Welfare publication (ADM) 76–361, (Washington, D.C.: U.S. Government Printing Office, 1976).

besides a roof over their heads. Because several such residential facilities often exist close together in the same neighborhood, these areas can quickly become stereotyped and isolated from the larger community. As Bachrach notes, "most reports indicate that on a widespread basis alternative living arrangements usually have fallen short of the desired goal of providing a humane environment."[10]

Another significant segment of the chronically mentally ill population can be found among the homeless (people without regular, reliable shelter). Few studies have been done of homeless populations, and those that exist cover only single cities or counties, but the evidence to date indicates that half or more of the samples in these studies are of people with diagnosable mental illness, most of whom have spent some time in public mental hospitals.[11]

The evidence from numerous studies strongly suggests that many basic needs of chronically mentally ill persons lie not in therapy or treatment for a mental condition, but in shelter, food, clothing, medical care, and provision of structure to their days, delivered within a rehabilitation framework. Traditional mental health programs have focused more on treatment or therapy and have not done enough to help former patients cope with the actual circumstances of maintaining a life in the community. Interactions between mental health agencies and other agencies have not been as extensive as needed, with the consequence that former patients do not obtain what they need from other agencies, even when they may be eligible for benefits. The exploration of federal programs in mental health in the next chapter describes services available for people with chronic mental illness, funded at least partially with federal dollars, and shows ways in which these programs have changed over the years as a result of changes in federal goals and favored strategies to meet them.

Summary

In this chapter we have defined chronic mental illness, described important ways that chronically mentally ill persons differ from the rest of the population, and looked at trends and issues affecting their well-being. At any

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10. Ibid., p. 16.

11. Colleen Cordes, "The Plight of the Homeless Mentally Ill," *APA Monitor*, vol. 15, no. 2 (February 1984), pp. 1–13. Dr. Ronald Manderscheid, Director of the Division of Biometry and Epidemiology, National Institute of Mental Health, summarized his reading of the existing studies as justifying an estimate in the range of 30 to 60 percent of the homeless who are chronically mentally ill. No greater precision is possible at this time, according to Manderscheid, because no adequate data exist at the national level (personal communication, 1985).

given time, approximately 1.7 million adults in the United States suffer from debilitating chronic mental illness. The chronically mentally ill experience varying degrees of disability over periods of one year or more—many have lifetime histories of impairment and inability to function in normal life. State and county mental hospitals once housed large numbers of the chronically mentally ill, but deinstitutionalization has removed from these facilities almost three-fourths of the population who lived in these facilities in 1955. The major shift came after 1965, with the advent of Medicaid.

Deinstitutionalization has left increasing numbers of chronically mentally ill persons dependent on the resources of local communities. These resources have usually proved less than adequate and often are completely nonexistent. Several federal programs have provided either direct support for the chronically mentally ill or have stimulated local services intended to provide care for these people. Changes during the Reagan administration have affected most of the programs. Chapter 5 describes the history of these programs and their current status.

CHAPTER 5

FEDERAL POLICIES AND PROGRAMS FOR THE CHRONICALLY MENTALLY ILL

Before 1963, when President Kennedy proposed and Congress passed the Community Mental Health Centers Construction Act, the federal government played a minimal role in providing care or support for the chronically mentally ill. State and local governments had almost exclusive responsibility for this population, which they exercised by maintaining state and county mental hospitals. A few chronically mentally ill persons received some benefits from federal programs, largely through the disability provisions of the Social Security Act and the Veterans' Administration. Veterans' Administration hospitals were the principal form of federal responsibility.

Since 1963 the federal government's involvement with programs and services for the chronically mentally ill has expanded, both directly and indirectly. Community mental health centers were supposed to provide direct services to this population. More important sources of financial support have been the Medicaid and Supplemental Security Income programs (Titles XIX and XVI of the Social Security Act, effective in 1965 and 1974, respectively). While neither of these programs was primarily intended to benefit the chronically mentally ill, both have provided significant resources for nursing home care and community living. Their availability has encouraged states to reduce the number of inpatients at mental hospitals by almost 75 percent between 1955 and 1980, with almost 90 percent of the reduction since 1963.

A historical frame of reference for mental health services and federal involvement with the chronically mentally ill is important because the Reagan administration inherited a state of affairs that was by no means ideal. Deinstitutionalization practices had left many chronically mentally ill "out in the cold" without adequate community services to compensate for the loss of state hospital residence. Federal policy, articulated through community mental health center legislation, repeatedly tried to focus services and attention on

the chronically mentally ill, but simultaneously expanded the mandate of the community mental health centers to include more and more populations and services. Since populations that are not chronically mental ill are easier to serve than chronically mental ill patients, these centers often took the path of least resistance (thus creating the need for federal policy to reiterate with each legislative reauthorization an interest in the chronically mentally ill). Policy decisions at the state and local level often rested more on fiscal considerations than on commitment to good services. In short, the mental health field was ripe for reorganization and improved targeting on the chronically mentally ill when Reagan assumed the presidency, and Congress had recently passed legislation to that end. The following review of federal actions briefly summarizes some important milestones affecting the chronically mentally ill from 1963 through 1983.

Community Mental Health Centers

In 1955 the Joint Commission on Mental Illness and Health was established to examine the circumstances and needs of persons with mental health problems. The commission, in its 1961 report to President Kennedy entitled "Action for Mental Health," detailed the deteriorated condition of most public mental hospitals and the largely custodial types of care they provided. At this time approximately 80 percent of patient contacts with the mental health system were inpatient episodes, mostly in public mental hospitals. The plight of long-term residents of mental hospitals appeared especially unacceptable, yet there was little expectation that state and county mental hospitals would be significantly upgraded through the funding provided by local resources.

The mental health movement in the early 1960s pushed for community-based care and rejected the notion that most mentally ill persons need hospitalization—especially long-term hospitalization—if adequate services exist to care for them in the community. Although based more on theory than on the presence of widespread community-based services, this philosophy become strongly embedded in the rhetoric behind the community mental health center concept. Implicit in the federal decision to finance these centers was an assumption that federal dollars would be needed in any case because the substantial improvement needed to make public mental hospitals into humane and therapeutic environments was very unlikely to come from state and local efforts.

Federal involvement thus arose from a sense of national responsibility for the chronically mentally ill population, articulated in the commission's report. This sense of responsibility was coupled with the idea that federal

investment would stimulate equal or greater state and local commitments, which would eventually replace federal support. Although by 1978 another study group, the President's Commission on Mental Health, reported that each federal dollar invested in community mental health centers had generated an estimated three dollars from nonfederal sources, the federal role in funding the centers never phased out as originally planned. Instead, during the two decades following enactment of the Community Mental Health Centers Construction Act (P.L. 88-164) in 1963, the act that authorized federal funding for the construction of such centers, Congress found itself routinely reassessing and extending the federal role in funding center development.

Amendments to the act in 1965 (P.L. 89-105) recognized that community mental health centers would need federal assistance with initial staffing requirements and authorized the use of federal funds for this purpose. Legislation in 1966 (P.L. 90-31) extended through 1970 the authorizations for construction and staffing of the centers. In 1968 more responsibilities for alcohol and drug abuse treatment were added to the centers' mission; children's facilities and services were added in 1970. Additional legislation in 1970 (P.L. 91-211) extended the basic community mental health centers' programs with an acknowledgment that local financing likely could not replace federal support as originally scheduled. Further, this law recognized that some high-poverty areas could not generate the matching funds required to begin developing a community mental health center and established special requirements for such locations (federal funds made up a greater percentage of total funds for these places). Further extensions and revisions of the 1963 act occurred in 1973, 1975, and 1978. The 1975 amendments in particular (P.L. 94-63) completely rewrote the act and expanded the centers' services and structures. Federal funding grew from a startup outlay of $30 million in fiscal 1965 to a high of $298 million in fiscal 1979. In fiscal 1981 the federal outlay was $270 million. About 20 percent of these funds served the chronically mentally ill.[1]

Between 1963 and 1978 the mission of community mental health centers expanded to include many populations in addition to the chronically mentally ill, so that by the end of the 1970s it was becoming increasingly clear that this population, for whom the centers were initially created, still did not receive the attention it needed. Both the President's Commission on Mental Health and the Department of Health and Human Services' Steering Com-

1. Based on data provided by the National Institute of Mental Health, Office of State and Community Liaison, from an unpublished document entitled "Total Federal Obligations for CHMCs, by State," n.d.

mittee on the Chronically Mentally Ill[2] recognized the continuing lack of services for the chronically mentally ill. For instance, the commission concludes:

> For many years, deinstitutionalization has meant being "dumped" into a community, to live in an inadequate boarding home or single room occupancy hotel. Former mental hospital patients were, thus, left without adequate food, clothing, recreation, or social services. . . .
> CMHCs have inadequately planned for and developed the community services required by the chronically mentally ill. . . .
> There is a lack in many communities of effective follow-up, outreach, and case management for the residents discharged from state mental hospitals.[3]

The Mental Health Systems Act of 1980 (P.L. 96-398) sought to refocus the efforts of community mental health centers to reach harder-to-serve persons, including the chronically mentally ill. The Carter administration used many of the recommendations in the report by the President's Commission on Mental Health to draft the provisions of the Mental Health Systems Act, which substantially revised the programming and structure of federal support for the centers. The act was signed into law in October 1980, just before the change from the Carter to the Reagan presidency. Most of its provisions were repealed by the Omnibus Budget Reconciliation Act of 1981, which created the alcohol, drug abuse, and mental health block grant to replace direct funding for the community mental health centers.

The Alcohol, Drug Abuse, and Mental Health Block Grant

The alcohol, drug abuse, and mental health block grant eliminated most of the provisions of the Mental Health Systems Act that created funding for specific populations, including the chronically mentally ill. It also significantly reduced the funding available from federal sources for mental health services.

Nothing in the wording of President Reagan's budget request or justification of the alcohol, drug abuse, and mental health block grant indicates that his administration wanted to abandon or change the basic program goals and objectives of federal mental health funding. Here, as with proposed budgetary and program structure changes for child welfare programs, the

2. President's Commission on Mental Health, *Report to the President from the President's Commission on Mental Health* (Washington, DC: U.S. Government Printing Office, 1978); and U.S. Department of Health and Human Services, Steering Committee on the Chronically Mentally Ill, *Toward a National Plan for the Chronically Mentally Ill*, Report to the Secretary, publication (ADM) 81-1077 (Washington, D.C.: U.S. Department of Health and Human Services, Public Health Service, December 1980).

3. Presidents' Commission on Mental Health, *Report to the President*.

Reagan administration retained a stated interest in pursuing program goals as expressed by earlier administrations. Rather, the administration simply applied its basic philosophy of government—its preference for reducing federal involvement and increasing state and local responsibility—to mental health funding along with funding for many other programs. In the process it repealed those aspects of the Mental Health Systems Act that were designed to encourage more attention to the chronically mentally ill without repudiating those goals, but also without retaining any mechanism that would assure local adherence to those goals. (Actually, as reported below, the state administrators who acquired new authority to control federal funds through the alcohol, drug abuse, and mental health block grant have been more committed to using those funds for the chronically mentally ill than the staff of the community mental health centers had been).

Table 11 gives the actual spending levels for the mental health component of community mental health center activities from 1978 through 1984, the federal budget requests for the first four years of the Reagan administration, and the spending levels adjusted for inflation. Except for the first year of the alcohol, drug abuse, and mental health block grant, 1982, Congress has consistently appropriated somewhat more money for mental health than the administration requested. These amounts have still fallen far short of the funding levels before the block grant, especially when one looks at the inflation-adjusted figures. Mental health programs have lost one-fourth of their purchasing power under the Reagan administration, as shown in the last column of table 11.

From the viewpoint of the states, mental health funding in the block grant is considerably less restricted than it was before 1982. Under the Community Mental Health Centers Act, federal funding went directly to community mental health centers, bypassing state mental health agencies and state priorities for mental health spending. The alcohol, drug abuse, and mental health block grant reduced the overall amount of federal money available within a state but increased state control over where that money was spent. The result, as reported in an Urban Institute study by Durman, Davis, and Bovbjerg,[4] is that mental health block grant funds are now being spent more in line with state priorities. This has some importance for the chronically mentally ill because state priorities have always been somewhat more directed toward this population than have federal priorities. For mental health, Durman et al. states "the federal ADM programs [alcohol, drug abuse, and mental

4. Eugene C. Durman, Barbara A. Davis, and Randall R. Bovbjerg, "Block Grants and the New Federalism: The Second Year Experience," Research Paper 3076-01 (Washington, D.C.: Urban Institute, April 1984), pp. 119–21.

TABLE 11

FEDERAL SPENDING FOR MENTAL HEALTH THROUGH COMMUNITY MENTAL HEALTH CENTERS OR ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH BLOCK GRANT, FISCAL YEARS 1978–85
(Millions of Dollars)

Federal Fiscal Year	*Administration Request*	*Percent Reduction from 1981 Spending Level*		*Actual Spending*	*Percent Reduction from 1981 Spending Level*	
		Current Dollars	*Constant Dollars*[a]		*Current Dollars*	*Constant Dollars*[a]
1978	...	...	...	267	...	...
1979	...	...	...	298	...	...
1980	...	...	...	252	...	...
1981	...	...	...	270	...	...
1982	216[b]	−20	−25	214[b]	−21	−25
1983	216[b]	−20	−28	234[b]	−13	−22
1984	220[b]	−19	−30	231[b,c]	−14	−26
1985	236[b]	−13	−28	...	...	...

SOURCES: Data for 1978 to 1981 were taken from unpublished budget documents provided by the National Institute of Mental Health, Office of State and Community Liaison. Figures for 1982 to 1985 were taken from Office of Management and Budget, *Budget of the United States Government* (Washington, D.C.: U.S. Government Printing Office, various fiscal years), appendixes. Actual spending figures for a given year appear in the budget document of two years later (for example, actual spending in 1982 was taken from the 1984 *Budget* appendix). Figures are rounded.

a. Using deflator calculated from unpublished document provided by Office of Management and Budget, "Federal Government Expenses, 1985 Budget Data," February 1984, tables 11 and 12.

b. Based on a formula for distribution of block grant funds among services for alcoholism, drug abuse, and mental health. Mental health receives approximately 50 percent of the total block grant funds.

c. Based on spending estimates given in appendix to the 1985 federal budget.

health] previously supplemented or paralleled state grant systems. . . . All of [the states] preside over community mental health budgets that dwarf the federal CMHC program."[5] Two states in the Durman et al. sample of eighteen states are described as requiring:

> CMHCs to serve chronically ill patients as their top service priority. The states' goal is to further their policy of deinstitutionalization by assuring services to former inpatients. Many states enforce such a policy for their state grantees;

5. Ibid., p. 106.

what is new since the block is its vigorous application to newer CMHCs once receiving only federal funds.[6]

Because of priority shifts, the history of state and federal funding patterns before the block grant and the phased nature of funding reductions, resources for mental health services supporting the chronically mentally ill have probably not suffered greatly from federal reductions, despite cuts in federal funding for the alcohol, drug abuse, and mental health block grant.

The Community Support Program

The Community Support Program of the National Institute of Mental Health began in 1977 as a federal initiative to stimulate states to do more for adults with chronic mental illness. The program is quite small in terms of federal dollars—states conducting demonstration projects under the program have received $20.5 million over a four-year period.[7] These projects involved states in efforts to develop systems of support for the chronically mentally ill in local communities. This federal initiative responded to many of the failings of the community mental health centers to provide such community support systems. Nowhere in the federal legislation or regulations were these centers required to provide posthospital planning services or after-care services to the chronically mentally ill once they left the hospital environment. Nor were the centers held responsible for coordinating care or services with non-mental-health agencies, despite the fact that housing, employment, recreation, and social services were often at least as important as mental health services to the success of a chronic mental patient in the community.

Contracts and grants from the Community Support Program to states support largely coordinating and development activities designed to increase state capacity to promote and maintain local community support systems. Very little of the money is spent on direct services. The program uses a rehabilitation framework in its approach to services to the chronically mentally ill. It assumes that people suffering from chronic mental illness nevertheless have a capacity for some degree of independent living. Services are structured to help these people achieve as much independence as is consonant with their maintaining a stable community living situation. The program goals are to reduce the "revolving door" phenomenon of repeated crisis hospitalizations, and to replace that pattern with stable community supports.

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6. Ibid., p. 121.

7. "The Community Support Program of the National Institute of Mental Health," unpublished document, Office of State and Community Liaison, National Institute of Mental Health, February 1984.

Evaluations of program projects indicate that community support systems can be quite successful at keeping chronically mentally ill individuals in the community and reducing the number of costly inpatient days they use each year. One of the premises behind the Community Support Program is that resources already exist in the community that can be coordinated to the benefit of the chronically mentally ill. The program's projects have tapped and organized those resources, including, most important, other federal funding mechanisms benefiting the chronically mentally ill. Chief among these have been Supplemental Security Income and Medicaid. The chronically mentally ill appear to be losing ground in both programs, however, due to administrative and regulatory changes made by the Reagan administration.

Supplemental Security Income

The Supplemental Security Income (SSI) program began in 1974. It is an entitlement program—all persons who meet its eligibility criteria may apply for benefits. Its purpose is to provide an income supplement to aged, blind, and disabled individuals whose Social Security or other income is insufficient to provide a minimum standard of living. Its placement in the Social Security Administration rather than a more welfare-oriented federal agency was intended to avoid welfare connotations and to make it possible for people to receive SSI payments with the same dignity associated with Social Security.

At least some congressional supporters of the initial legislation perceived it as focused on the elderly, or at least on persons who had substantial work histories before becoming disabled.[8] In 1981, 50 percent of SSI recipients had such work histories, as indicated by their also receiving Social Security benefits. However, individuals in the three SSI eligibility categories have quite different patterns of participation in both programs—70 percent of the aged but only 38 percent of the blind and 36 percent of the disabled receive both SSI and Social Security benefits.[9] Disabled SSI recipients, of which the chronically mentally ill constituted approximately 18 percent in 1977,[10] are

8. U.S. Congress, Senate, Committee on Finance, *The Supplemental Security Income Program*, 95th Cong., 1st sess. (Washington, D.C.: U.S. Government Printing Office, 1977).

9. U.S. Department of Health and Human Services, Social Security Administration, *Social Security Bulletin, Annual Statistical Supplement, 1981*, (Washington, D.C.: U.S. Government Printing Office, 1981), table 169.

10. Ibid., table 178. Reported data are for 1977, the last year available. They indicate the chronically mentally ill comprise 17.7 percent of the disabled SSI recipients at the time of initial eligibility determination.

thus much less likely than aged SSI recipients to have participated in the work force long enough to qualify for Social Security benefits.

SSI Recipients

Table 12 summarizes participation in SSI from 1980 through 1983, with estimates included for 1984 and 1985. The table also includes information from January 1974, the first month of SSI operation. All figures except those for 1974 and those for the chronically mentally ill are taken from presidential budget documents prepared by the Reagan administration. Figures for the chronically mentally ill were calculated as a fixed percentage of the "blind and disabled" category, based on the only available estimate of this percentage

TABLE 12

NUMBER OF PERSONS RECEIVING FEDERAL SUPPLEMENTAL SECURITY INCOME, SELECTED YEARS, 1974–85
(Thousands unless Otherwise Indicated)

Category	*1974*	*1980*	*1981*	*1982*	*1983*	*1984 (Estimate)*	*1985 (Estimate)*
Aged	1,690	1,584	1,506	1,452	1,333	1,400	1,387
Blind and disabled[a]	1,265	2,116	2,157	2,157	2,176	2,267	2,327
Chronically mentally ill[b]	217	363	370	370	374	389	400
Blind and disabled (percent of total)	42	57	59	61	62	59	63
Total	2,955	3,700	3,663	3,562	3,509	3,667	3,714

SOURCES: Data for 1974 are from U.S. Department of Health and Human Services, Social Security Administration, *Social Security Bulletin: Annual Statistical Supplement, 1981* (Washington, D.C., U.S. Government Printing Office, 1981) table 157; these data represent recipients at the beginning of the SSI program, January 1974. Figures for 1980 are from Office of Management and Budget, *Budget of the United States Government, Fiscal Year 1982* (Washington, D.C.: U.S. Government Printing Office, 1982), appendix (hereafter referred to as the *Budget*); for 1981, *Budget, Fiscal Year 1983*, appendix; for 1982, *Budget, Fiscal Year 1984*, appendix; and 1983–85, *Budget, Fiscal Year 1985*, appendix. Figures are rounded.

a. Approximately 3 percent of the "blind and disabled" are blind. Approximately 20 percent of the "blind and disabled" are 65 and older.

b. The "blind and disabled" category × 0.97 = disabled × 0.177 = percentage chronically mentally ill. These figures assume that the proportion of the disabled who are chronically mentally ill has remained constant at 17.7 percent since 1977, the last year for which diagnosis data are available (*Social Security Bulletin, Annual Statistical Supplement, 1981*, table 178). However, the contention of many service providers is that the chronically mentally ill are being disproportionately dropped from the SSI rolls or rejected at application.

by the Social Security Administration.[11] It should be noted that this method does *not* yield the true number of chronically mentally ill individuals receiving SSI in the years after 1977; these figures are nowhere available. The evidence for disproportionate reductions in chronically mentally ill persons from the SSI rolls will of necessity take the form of publications and testimony by agencies that determine SSI eligibility or provide services to the chronically mentally ill.

The data in table 13 indicate that a relatively stable proportion of between 57 and 63 percent of SSI recipients between 1980 and 1985 are eligible by reason of blindness or disability. This represents approximately a 15 to 20 percent increase over the initial distribution of recipients in 1974. To place this increase in perspective, the rate of disability per 1,000 U.S. population increased 13 to 19 percent (depending on the source of estimates) between 1972 and 1978.[12] The disabled individuals exceeded 50 percent of the SSI rolls for the first time in 1976, just two years after the program began. The table shows a steady decrease in the absolute numbers of aged recipients between 1980 and 1983, and there was a slight decline in their proportional representation (not shown). This pattern has held since 1976. The number of blind persons receiving SSI has remained relatively constant and the number of disabled recipients has increased in absolute numbers as well as proportionally. Our estimate, based on 1977 data, is that approximately 370,000 to 375,000 chronically mentally ill persons a year receive SSI benefits. This represents between 20 and 25 percent of the estimated 1.7 million persons with chronic mental illness in the U.S. population.

Federal Support for SSI

SSI and the Medicaid eligibility it entails reflect far greater federal investment in support for the chronically mentally ill than any investment in community mental health centers. Table 13 presents the federal outlays (excluding state supplements) for SSI payments to all recipients, to the blind and disabled, and estimates for the chronically mentally ill, for the years 1980 through 1983. It also includes estimates for 1984 and 1985, and 1974 data for historical comparison.

As can be seen from the table, estimates of SSI payments for the chronically mentally ill indicate federal expenditures of $632 million in 1980, increasing to slightly more than $1 billion projected for 1985; this is an

11. Ibid.

12. John W. Ashbaugh et al., "Estimates of the Size and Selected Characteristics of the Adult Chronically Ill Population Living in Households," *Research in Community and Mental Health*, vol. 3 (1983), pp. 3–24.

TABLE 13

FEDERAL SSI PAYMENTS TO THE CHRONICALLY MENTALLY ILL, SELECTED FISCAL YEARS, 1974–85
(Millions of Dollars unless Otherwise Indicated)

Payment Category	*1974*	*1980*	*1981*	*1982*	*1983*	*1984 (Estimate)*	*1985 (Estimate)*
Total payments	3,833	6,434	7,170	7,604	8,683	8,471	9,346
Blind and disabled[a]	2,050	3,680	4,223	4,605	5,384	5,237	5,856
Chronically mentally ill[b]							
Current dollars	352	632	725	791	924	899	1,005
Constant 1972 dollars	313	355	374	383	429	396	426
Maximum allowable monthly payment (dollars)[c]							
Current dollars	146	208	238	265	284	314	325
Constant dollars	130	117	123	128	132	140	136

SOURCES: Data for 1974 are from *Social Security Bulletin, Annual Statistical Supplement, 1981*, tables 158 and 159; data for 1980 are from *Budget, Fiscal year 1982*, appendix; for 1981, *Budget, Fiscal Year 1983*, appendix; for 1982, *Budget, Fiscal Year 1984*, appendix; for 1983–85, *Budget, Fiscal Year 1985*, appendix.

a. Proportional to the ratio of blind and disabled to all recipients, as given in appendices to the federal budget for 1982–85.

b. The "blind and disabled" category × 0.97 = disabled × 0.177 = percentage chronically mentally ill. These figures assume that the proportion of the disabled who are chronically mentally ill has remained constant at 17.7 percent since 1977, the last year for which diagnosis data are available (*Social Security Bulletin, Annual Statistical Supplement, 1981*, table 178). However, the contention of many service providers is that the chronically mentally ill are being disproportionately dropped from the SSI rolls or rejected at application.

c. Payment for a single person living alone or in a community residential facility. See *Social Security Bulletin, Annual Statistical Supplement, 1983*, p. 42. Benefits increase by same percentage and at the same time as Old Age, Survivors, Disability, and Health Insurance (OASDI).

apparent increase of almost 60 percent. In constant 1972 dollars the increase is 36 percent, which is still a substantial real increase. As one can infer from table 14, by looking at the last two rows for average monthly payments, most of these increases are attributable to inflation or to increasing numbers of persons on the rolls. Persons who continuously received SSI payments during the period shown in the table would maintain their position with respect to inflation, but would not experience any significant increase in their overall ability to purchase goods and services. In fact, in 1980, 1981, and 1982, SSI recipients would have received fewer inflation-adjusted dollars than they got

in 1974. The increase in real spending power between 1974 and 1985 is just 4.6 percent.

Note the contrast between SSI support and community mental health center funding. Of the $214 million to $298 million spent for community mental health center services annually between 1980 and 1984, a high estimate of the proportion devoted to services for the chronically mentally ill is 20 percent, or $43 to $60 million per year.[13] SSI expenditures thus equal ten to twenty times as much money as specifically targeted mental health services.

The Importance of SSI for the Chronically Mentally Ill

SSI provides major federal support for the chronically mentally ill but its importance is not measured in terms of the magnitude of dollars alone. Rather, SSI payments, because they go directly to the recipients to dispose of according to their own needs, provide essential goods and services not available through community mental health centers or other mental health services.

As expressed in congressional testimony by a deputy commissioner of the New York State Office of Mental Health, which operates thirty-two psychiatric centers serving 46,000 inpatients and 77,000 outpatients and licenses or funds an additional 900 mental health programs,

> We are experiencing the effects of the changes in the disability determination process as we submit applications for the patients served in the programs we operate, as we admit patients who have decompensated when their disability payments have been threatened or ceased, and as we are called upon to provide additional funding and support to the programs we regulate because of the reduction in disability payments.
>
> The significance of the [Social Security Disability Income, SSDI] and SSI programs in providing basic income support to the mentally ill living in the community is, too often, not fully recognized. I would, therefore, like to provide some data to put this into perspective:
>
> Of a total 2.3 million SSI recipients nationally, approximately 750,000 are mentally ill. For New York State, this means that approximately 75,000 mentally ill individuals receive $310 million in income support.
>
> Of a total of 4.4 million [SSDI] recipients nationally, 485,000 are mentally ill. Again, for New York State this means approximately 48,500 mentally ill individuals and $165 million in income support.
>
> Moreover, many of the community based residential programs established to support the most seriously mentally ill individuals in the community are

13. In its attempt to refocus community mental health centers efforts on underserved populations, the Mental Health Systems Act of 1980 stipulated that approximately 20 percent of funding for these centers should be devoted to the chronically mentally ill. The act recognized that this would constitute an *increased* level of effort for services for this population.

> dependent upon the residents' receipt of disability payments. In New York State there are two such programs:
>
> The community residence program provides shelter and supervision for individuals in apartments or freestanding housing. Of approximately 2,000 residents, 1,300 are on SSI or [SSDI].
>
> The family care program supports one to six individuals living with a family. Of 2,700 participants, 2,400 are on SSI or [SSDI].
>
> In addition, SSI and [SSDI] entitlement carries with it entitlement for coverage of health and mental health services through the Medicaid or Medicare program. Loss of entitlement jeopardizes eligibility for these programs as well.[14]

Much discussion of deinstitutionalization has made clear that chronically mentally ill individuals in the community need services that replace the custodial or maintenance aspects of mental hospitals.[15] Equally clear is the fact that often they do not receive these services. Finding and paying for housing is an overwhelming problem, but so are obtaining adequate food, clothing, transportation, human contact and daily activities, medical and dental care, and management of medications necessary to maintain psychological equilibrium. Mental health programs, including community mental health centers, have not traditionally provided most or all of these services, nor have they offered the case management assistance often necessary to assemble an adequate array of supports for normal living. When experts speak of "dumping" deinstitutionalized chronically mentally ill people on the community, they mean that people have been released from public mental hospitals without having either a plan for how to obtain the services they need or the resources to purchase them. Therapy, the traditional "stock in trade" of community mental health centers and other mental health agencies, is a much lower priority for the chronically mentally ill than finding a stable source of shelter and food. SSI payments to chronically mentally ill persons provide the financial resources to purchase what they need.

SSI and the state supplemental payments that often accompany it enable the chronically mentally ill without families to pay for board and lodging in community residential facilities. These facilities sometimes include other services, such as managing medications or finances. Recipients' payments usually cover the cost of such care, with a little left over for incidental expenses,

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14. Joanne K. Hilferty, Deputy Commissioner for Quality Assurance and Finance of the New York State Office of Mental Health, prepared statement in *Social Security Disability Benefits Terminations: New York*, Hearing before the Subcommittee on Retirement Income and Employment of the House Select Committee on Aging, 97th Cong., 2d sess., committee publication 97-353 (Washington, D.C.: U.S. Government Printing Office, July 1982), p. 34.

15. Leona L. Bachrach, *Deinstitutionalization: An Analytical Review and Sociological Perspective*, U.S. Department of Health, Education, and Welfare, publication (ADM) 76-361 (Washington, D.C.: U.S. Government Printing Office, 1976).

because the size of state supplements is usually geared to prevailing rates in community residential facilities. In addition, SSI carries with it another critical source of support—recipients are categorically eligible for Medicaid.

Medicaid eligibility means that chronically mentally ill SSI recipients can obtain psychotropic medications that enable them to remain in the community, medical and dental care for general physical ailments not related to their mental illness, and periodic inpatient care when necessary. Table 14 provides estimates for the federal share of medical assistance payments for the chronically mentally ill from 1980 through 1984. As with SSI payments, Medicaid financing for the chronically mentally ill greatly exceeds federal financing for special mental health programs—in this case by a factor of seven or more. Estimates are based on the assumption that the disabled in general, and the chronically ill in particular, absorb a simple proportional

TABLE 14

MEDICAL ASSISTANCE (TITLE XIX) PAYMENTS FOR THE CHRONICALLY MENTALLY ILL, FISCAL YEARS 1980–84
(*Millions of Dollars*)

	Total Outlays under Title XIX (All Recipients)	*Federal Share (All Recipients)*	*Federal outlays*		*Total outlays*	
Year			*Disabled*[a]	*Chronically Mentally Ill*[b]	*Chronically Mentally Ill*	*Constant 1972 Dollars*
1980	24,557	13,826	1,956	346	615	312
1981	28,828	16,153	2,015	357	637	298
1982	30,879	16,589	2,150	381	708	311
1983	33,700	18,245	2,379	421	778	328
1984	36,575	19,616	2,580	457	775	312

SOURCES: Data for 1980 are from *Budget, Fiscal Year 1982*, appendix, actual expenditures; for 1981, *Budget, Fiscal Year 1982*, appendix, actual expenditures; for 1982–84, *Budget, Fiscal Year 1984*, appendix, actual expenditures. Data for 1983 and 1984 are estimates. The appendix to *Budget, Fiscal Year 1985* does not give this information. Figures are rounded.

a. The federal share (second column) multiplied by number of disabled recipients divided by number of total recipients. AFDC adults and children, poor elderly, blind and disabled individuals, SSI recipients, and other eligibles receive Medicaid. AFDC recipients use less than their proportional share of Medicaid dollars, whereas the aged use proportionately more. The disabled fall in between, but because their disabling condition almost always entails significant ongoing medical expenses, they resemble the elderly more than the AFDC population in their use of Medicaid.

b. Federal outlays for the disabled (third column) multiplied by 17.7 percent (the proportion of SSI disabled recipients who are chronically mentally ill).

share of Medicaid expenditures.[16] Because Medicaid coverage entails state and local matching funds almost equivalent to federal expenditures, the total public outlay for medical care for the chronically mentally ill can be estimated at between $600 million and $800 million annually from 1980 to 1984.

Changes in Social Security Administration Procedures

The expenditures just detailed, which contribute the lion's share of federal investment in services and support for the chronically mentally ill, are obviously critically important to the well-being of many persons affected by mental illness. However, new procedures pursued by the Social Security Administration during Reagan's presidency have made it more difficult to establish eligibility for SSI. Equally important, new redetermination procedures that review the continuing eligibility of people already receiving SSI have terminated SSI benefits for many long-term recipients.

During the last year of the Carter administration, the Social Security Disability Amendments of 1980 (P.L. 96-265) mandated several administrative changes. These included periodic review at least once every three years of many disability cases that previously had not been reviewed. Congress established January 1982 as the date for beginning these reviews, but the Reagan administration accelerated the process and began in March 1981, just two months after taking office. These reviews covered persons receiving Social Security Disability Income only and persons receiving both this income and SSI.

A report compiled by the state of Michigan relates the following:[17]

> the SSI disability program grew beginning with its enactment in 1974, and appeared to continue this growth until January 1982. By taking into account the SSA practice of categorizing SSI recipients over age 65 as "disabled" rather than "elderly," it becomes clear that SSI disabled caseloads have dropped to their 1976 levels (i.e., the number of disabled SSI recipients *under* 65 years of age equalled 1.8 million in both 1976 and 1982).

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16. AFDC children and adults, who comprise two-thirds of medicaid recipients, absorb much less than their proportional share of medicaid payments. The elderly, who make up 17 to 18 percent, absorb much more than their proportional share, due largely to nursing home costs. The disabled comprise 14 to 15 percent of Medicaid recipients and have regular medical expenses associated with their condition plus periodic inpatient or nursing home stays. Assigning them a proportional share of Medicaid expenses thus seemed both reasonable and the simplest way to estimate their share of federal Medicaid outlays.

17. This and the other quotation in this paragraph are from Philip Michel, *The SSI/SSDI Controversy: How and Why the Social Security Administration has Reduced the Number of SSI/SSDI Beneficiaries* (Ann Arbor, Michigan: State of Michigan, Interagency Task Force on Disability, April 1983).

> The decline in caseload was preceded by a decline in approvals which began in 1976 and has continued to the present . . . approvals for SSI have reached the lowest level in the program's history. (p. 24)

The Social Security Administration began large-scale reviews of all current recipients in March 1981, immediately after the Reagan administration assumed office.

> [These] large scale increases in the number of reviews, termed "Continuing Disability Investigations (CDIs)" caused multiple thousands of clients to be reevaluated under more rigid procedures which had, by 1981, become standard. These periodic reviews using narrower standards caused nearly half of the beneficiaries examined to be declared ineligible for further benefits . . . many of the recipients terminated as a result of CDIs remained "disabled" under almost any definition of that word. (p. 3)

The chronically mentally ill have been among the hardest hit by these terminations. In specific reference to people with mental disorders, the report quotes a December 1981 letter to the federal Region V assistant regional commissioner from the director of Wisconsin's Disability Determination Bureau, stating that "the current adjudicative climate involving mental impairments seems to be one of deny, deny, deny" (p. 16). This opinion is echoed in testimony before the U.S. Congress in 1982. One report from New York City summarizes a study of accelerated continuing disability investigations:

> Over 160,000 people receive Social Security Disability (SSD) and Supplemental Security Income (SSI) benefits each month in New York State as a result of being mentally disabled and unable to work. Many of these people are state psychiatric hospital dischargees, living in single room occupancy hotels, adult homes, and community residences. They are dependent on federal disability benefits to buy food and pay the rent.
>
> Thousands of these chronically ill, mentally disturbed men and women will lose these benefits due to a federal initiative to reexamine the eligibility of all disabled Social Security beneficiaries. While the publicly stated intent of this action is to eliminate improper payments to employable people, the harsh reality is that many "truly" mentally disabled are being terminated as well. The fact that they still suffer from recurring and debilitating mental illness is apparently being routinely ignored.
>
> An estimated 5,500 mentally disabled beneficiaries in New York State (including 2,300 in New York City) will lose benefits in federal fiscal year 1982 alone. This federal initiative is yet another way in which the Reagan administration is removing the federal safety net for helpless people dependent on government benefits for survival.
>
> The outcome of this process is all too predictable. After losing federal disability benefits, some people will apply for the public assistance program of last resort, Home Relief, further increasing state and local welfare costs. The

> less fortunate will end up destitute on the streets, causing yet another surge in the number of homeless people in New York City.[18]

At the same congressional hearing, the deputy commissioner of the New York State Department of Social Services testified, based on a study of 451 terminated cases:

> The Department of Social Services has initiated a study of claimants whose benefits have been terminated to identify their characteristics and needs. The preliminary results of this study support our impressions regarding the vulnerable nature of this population. The data suggest that the typical individual losing benefits is a single male aged forty-one with no other source of income and a limited residual functioning capacity. He is most likely to be suffering from a mental illness, particularly schizophrenia, or from a musculoskeletal disorder such as a back problem. The questionable prospects for employment for such individuals is supported by the finding that nearly a quarter of those who have lost benefits have made a new application for public assistance. This percentage will grow with time.[19]

Administrative Changes in Disability Definitions

In addition to reviews of continuing eligibility, the Social Security Administration began enforcing a more stringent definition of disability for both initial and continuing eligibility. This was done through changes in the policy manual governing disability determinations, but was never submitted to public scrutiny or acceptance through either legislative or rule-making procedures. Indeed, Congress has declined since 1977 to change the definition of disability through several sessions in which it explicitly addressed the issue.[20]

Three categories exist for determining eligibility. The first of these is made up of a number of disabling conditions specified by the Social Security Administration. Applicants qualify as "meets level of severity" if they have one of these conditions. The second category, known as "equals level of severity," allows the worker determining eligibility to assess the applicant's condition and make the judgment that that person's level of disability equals that of other people who qualify because they have the specific conditions

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18. Office of the City Council President, New York City, "Passing the Buck: Federal Efforts to Abandon the Mentally Disabled," reproduced in *Social Security Disability Benefits Terminations: New York*, pp. 136–75.

19. Nelson Weinstock, Deputy Commissioner, Division of Operations, New York State Department of Social Services, prepared statement in *Social Security Disability Benefits Terminations: New York*, p. 18. The study to which Weinstock refers also appears in the hearing record, "Accelerated Continuing Disability Investigation Cessations: A Characteristics Profile of Affected Persons," pp. 176–267.

20. Philip Michel, *The SSI/SSDI Controversy*.

allowed in the first category. The third category, "medical and vocational consideration," includes persons whose level of functioning does not quite qualify them as severely disabled, but whose age, previous work experience, or other mitigating factors make it extremely unlikely that they could find and maintain a job.

The Social Security Administration has reduced state agencies' flexibility in determining disability by making it extremely difficult to qualify anyone for benefits unless they fall into the first category—that is, the applicant must have one of the disabling conditions specified by the policy manual. Table 15 shows why this approach has been particularly hard on chronically mentally ill applicants and beneficiaries.

The table gives the distribution for the three categories of eligibility for chronically mentally ill recipients of SSI, for all other recipients, and for all recipients. These data come from eligibility determinations in 1977, the most recent year available. The chronically mentally ill are significantly overrep resented in the second category, "equals level of severity," and underrepresented in the first category. New Social Security Administration procedures greatly favor the first category over the second and third. Thus, any group with a lower probability of qualifying due to a specific disabling condition acceptable to the Social Security Administration will suffer disproportionately under the new qualifying and review procedures. This has been true for the chronically mentally ill. (It has also been true for those with musculoskeletal problems, the most populous condition in the third category.) As the New York State deputy commissioner for the Office of Mental Health summarizes:

> The changes in the review process are difficult for all the disabled, but are particularly so for the mentally ill. The cycle of chronic mental illness is such

TABLE 15

ELIGIBILITY CHARACTERISTICS OF ADULT SSI RECIPIENTS, 1981

Item	*Mentally Ill Recipients*	*All Other Recipients*	*Total Recipients*
Total number of recipients	51,136	237,768	288,904
Percent of total	17.7	82.3	100.0
Social Security category (percent)			
"Meets level of severity"	35.0	41.0	40.0
"Equals level of severity"	54.0	34.0	38.0
"Medical and vocational consideration"	11.0	25.0	22.0
Total	100.0	100.0	100.0

SOURCE: *Social Security Bulletin, Annual Statistical Supplement, 1981*, table 178. Percentages are rounded.

> that an individual may, under low stress and with the right supports, be able to live in the community. We've made tremendous strides in New York in supporting people in the community. But, if the federal government pulls their basic income support out from under them, there is no easy way to provide a stable living environment. For the chronically mentally ill, a stable living environment is essential to permit them to maintain themselves in the community.[21]

Pressures on the Social Security Administration from Congress and elsewhere resulted in a suspension of continuing disability investigations in mid-1984. In addition, Congress is considering legislation to clarify that the Social Security Disability Amendments of 1980 were never intended to authorize more severe standards resulting in widespread findings of ineligibility for recipients of SSDI and SSI payments. It remains to be seen what effects these legal and administrative changes will have on the ability of the average chronically mentally ill person to obtain and retain eligibility status.

Summary

When President Reagan took office in 1980, the mental health system's ability to support the needs of the chronically mentally ill was open to question. The Mental Health Systems Act had just been passed after long congressional consideration of how to restructure the federal role in that system. The new administration had the opportunity to increase federal focus on the chronically mentally ill and promote greater concentration of federal effort than had previously existed. Nowhere did the administration reject long-standing federal policy to benefit this population.

This chapter has reviewed the history, from 1963 to the present, of the federal programs most relevant to the chronically mentally ill. The initial federal support for community mental health centers in 1963 was based on an intent to improve the well-being of the chronically mentally ill, then residing almost entirely in state and county mental hospitals. Yet community mental health centers never fulfilled that intent, despite repeated federal efforts to focus their efforts on the chronically mentally ill.

The shift of community mental health center support to block grant funding in 1982 put more resources directly in the hands of state mental health agencies, whose priorities have always focused on the chronically mentally ill. As a result, services provided for the chronically mentally ill using block-grant funding do not appear to have suffered greatly, despite an inflation-adjusted cut of approximately 25 percent in overall funds available. Admin-

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21. Hilferty, prepared statement in *Social Security Disability Benefits Terminations: New York*, p. 31.

istrative changes in initial and continuing eligibility for Supplemental Security Income, also affecting Medicaid eligibility, have much more seriously affected the well-being of the chronically mentally ill. These two programs contribute ten to twenty times more federal resources for the chronically mentally ill than does funding for community mental health centers. The effects of severely tightened eligibility criteria for mental disabilities has been felt throughout the country, as we detail in chapter 6.

Enabling the chronically mentally ill to maintain themselves in the community through coordinated systems of services (promoted by the Community Support Program) and financial resources (SSI) is cost-effective in the long run, but only if one adopts the perspective of the whole public.

CHAPTER 6

WHAT HAS HAPPENED TO THE CHRONICALLY MENTALLY ILL?

This chapter explores the ways in which changes in federal programs affect the lives of chronically mentally ill service recipients at the local level. Our basic approach has been to look at service patterns and recipients of those services at the local level through visits and data collection in four cities.[1] We report on San Diego City and County, Detroit (Wayne County), Richmond (which is its own county-equivalent jurisdiction) and Massachusetts State Region VI, which includes Boston.

We look first at the overall change in state funding patterns for the services covered in the alcohol, drug abuse, and mental health block grant. We then look at budget changes for mental health services in each of the cities we visited. Then, to put flesh on the budgetary skeleton, we describe the structure of services for the chronically mentally ill in each city, the size and other characteristics of the chronically mentally ill client population, and changes in service patterns. To the extent possible, we also describe the reasons for changes, such as direct fiscal or policy responses to federal changes, independent state or local fiscal or policy changes, or the recession. The chapter concludes with an assessment of the overall impact of federal policy on the chronically mentally ill between 1981 and 1983.

State Funding Patterns

Of the four states (California, Michigan, Virginia, and Massachusetts) in which the selected cities are located, two experienced real growth in their alcohol, drug abuse, and mental health financing between 1981 and 1983, and two

1. The criteria and methods for selecting the cities are explained in the introduction to this book.

experienced real funding losses. Table 16 displays the funding patterns in these four states, with details on funding sources and on both the nominal dollar change (current dollars) and the real change after inflation (constant dollars).[2] The data in the table do not report funding for mental health separately; rather, all funding is combined that is relevant to alcohol, drug abuse, and mental health block-grant activities, regardless of target population.

In all four states the real losses associated with this block grant funding are substantial and would have been greater if the respective states did not have carry-over funding available. California also reported significant reductions in funding from Title XIX (Medicaid) and Title XX for alcohol, drug abuse, and mental health functions. Michigan and California increased their use of other federal funds, but the total amount of money involved was very small. In three of the four states spending at the state level increased in nominal terms, but in two of the four the state resources devoted to alcohol, drug abuse, and mental health decreased in real purchasing power. California experienced the biggest loss in state support for these activities. However, community mental health programs in Massachusetts suffered disproportionally, despite overall increases in state revenues.

According to Department of Mental Health staff in Massachusetts, funding for community mental health centers was reduced because the governor rejected a former state policy of picking up this funding when federal support expired. The Department of Mental Health was unable to win replacement funds from the Massachusetts legislature in large part because governor King refused to supplement federally funded programs without a previous written agreement. Written contracts between community mental health centers and the state turned out to be virtually nonexistent. The reduction in state monies reflects a statewide austerity and denotes a lack of state support for the expansion of community services for the mentally ill. Because the Department of Mental Health decided against supporting the centers with other departmental monies when federal cutbacks occurred, the burden of reduced funds fell almost totally on the centers. The average community mental health center program absorbed cuts ranging from 30 to 34 percent, according to a study on block-grant implementation and federal cutbacks by the Massachusetts Human Services Coalition.[3]

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2. Constant dollars were calculated using deflators derived from Office of Management and Budget, "Federal Government Expenses, 1985 Budget Data" unpublished document (Washington, D.C.: February 1984), tables 11 and 12. Except for SSI, the deflators used were for "all other grants and contracts" the deflators for payments to individuals were used for SSI.

3. Massachusetts Human Services Coalition, *Analysis of Human Services Block Grants in Massachusetts* (Boston, Massachusetts: MHSC, 1983).

TABLE 16

CHANGES IN FUNDING SOURCES FOR ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH SPENDING, STATE FISCAL YEARS 1981–83
(*Millions of Dollars*)

State and Funding Source	*1981*	*1982*	*1983*	*Percent Change, 1981–83*	
				Current Dollars	*Constant Dollars*
California					
Block grant and carry-over	57.3	49.0	41.4	−27.7	−34.7
Other federal	0.3	0.5	0.8	166.7	141.0
State	417.9	417.1	411.8	−1.5	−10.9
Titles XIX and XX	48.8	47.2	43.3	−11.3	−19.8
Local and other	16.0	36.9	51.2	220.0	289.1
Total	540.3	550.7	548.5	1.5	−8.3
Massachusetts[a]					
Block grant and carry-over	22.4	20.5	18.5	−17.4	−25.4
Other federal	0.6	1.0	0.8	33.3	12.1
State	46.6	53.5	61.9	32.8	20.0
Titles XIX and XX	0.0	0.0	0.0	...	...
Local and other	2.9	3.7	1.6	−44.8	−50.1
Total	72.5	78.7	82.8	14.2	3.2
Michigan[a]					
Block grant and carry-over	11.5	11.0	11.2	−2.6	−12.0
Other federal	0.3	1.2	1.0	233.3	201.3
State	497.8	529.8	537.7	8.7	−1.8
Titles XIX and XX	0.5	0.4	1.4	180.0	153.1
Local and other	19.4	22.7	25.7	32.5	12.0
Total	529.5	565.1	577.0	9.0	−1.0
Virginia					
Block grant and carry-over	8.5	10.4	7.7	−9.4	−19.1
Other federal	0.7	0.6	0.7	0.0	0.0
State	6.5	8.3	10.1	55.4	40.4
Titles XIX and XX[b]	...	...	...	...	...
Local and other	7.3	7.7	8.1	11.0	0.3
Total	23.0	27.0	26.6	15.7	4.5

SOURCE: Data provided by states and taken from Eugene C. Durman, Barbara A. Davis, and Randall R. Bovbjerg, "Block Grants and the New Federalism: The Second Year Experience," Research Paper 3076-01 (Washington, D.C.: The Urban Institute, April 1984), table 23. Data for Michigan state mental health expenditures are from Michigan Department of Mental Health, *Impact of Budget Reductions—1983* (Lansing, MI.: MDMH, 1983).

a. Data based on federal fiscal years.

b. Included in "Other federal."

A special report by the Michigan Department of Mental Health details the actual and anticipated budget reductions for mental health in that state from fiscal 1979 to fiscal 1983.[4] In fiscal 1980 the Michigan legislature appropriated $494.7 million for mental health programs; in fiscal 1983 the appropriations totaled $537.7, a small increase in actual dollars but a significant decrease in real dollars

To partially compensate for loss of state and federal revenues, local sources of funding increased greatly in California. However, this increase was insufficient to maintain statewide alcohol, drug abuse, and mental health services at the 1981 level. Only in Massachusetts did local revenues drop substantially. Michigan experienced a modest increase in local funding, while Virginia's local funding support remained relatively constant.

City and County Funding Patterns

The relatively benign picture painted by the state data in table 16 does not hold for the local data in the four cities we visited for intensive data collection. Tables 17 through 20 present the information on funding patterns for these cities and counties equivalent to that given for the state level in table 16, except that the city and county data pertain only to mental health programs rather than to all alcohol, drug abuse, and mental health functions.

Two cities, Richmond and Boston, show both nominal and real (after inflation) budget cuts, as tables 19 and 20 indicate. Richmond's mental health funding levels in 1983 were 18 percent lower in real terms than in 1981. Boston's funding declined 23 percent after inflation. In neither case did federal cuts have much effect on budget reduction. In Richmond mental health services did not rely on federal money at all, while federal funding in Boston amounted to less than 5 percent of the overall mental health budget for the years under study. State reductions brought most of the losses in the Boston area. Richmond lost funding from almost all sources; there the state alone increased its contribution to mental health services.

On the surface, table 17 suggests that San Diego's mental health budget showed no real dollar change between 1981 and 1983. However, totals for 1983 include $2.7 million transferred from the state to the county to cover mental health care for medically indigent adults.[5] MediCal (California's Med-

4. Michigan Department of Mental Health, *Impact of Budget Reductions—1983* (Lansing, Michigan: MDMH, 1983).

5. A medically indigent adult is any person who needs but cannot pay for medical care and does not qualify for federal medical assistance. The category includes, but is not limited to, people with chronic mental illness.

TABLE 17

SAN DIEGO BUDGET FOR MENTAL HEALTH PROGRAMS, STATE FISCAL YEARS 1981–83
(Thousands of Dollars)

Item	*1981*	*1982*	*1983*[a]	*Percent Change, 1981–83*	
				Current Dollars	*Constant Dollars*
Services					
Adult inpatient	7,477	7,264	7,794	4	−6
Adult partial day	3,363	4,686	4,107	22	10
Adult community services	2,764	3,396	3,851	39	26
Adult outpatient	6,403	7,015	6,338	−1	−11
Funding[b]					
State	13,758	13,994	14,014	2	−8
			(11,314)	(−18)	(−26)
County	1,715	3,696	2,717	60	45
Charges[c]	4,533	4,672	5,330	18	6
Total	20,006	22,360	22,091	10	0
			(19,291)	(−4)	(−13)

SOURCE: San Diego County, Department of Health Services budget documents.

a. Includes $2.7 million in state payments for medically indigent adults (see text for description) that was not handled through the county system in 1982 or earlier. New recipients came with the new money.

b. The numbers in parentheses were calculated without the $2.7 million for medically indigent adults.

c. Includes MediCal payments, patient fees, and insurance payments. MediCal accounts for approximately half of this category.

icaid program) previously provided care for these persons, but with 100 percent state funding.

Before 1983, San Diego County had no financial or case-management responsibility for people in this category. Further, the $2.7 million set aside for the medically indigent in 1983 represents about 70 percent of what the state had spent on these people in past years. Thus the county received both more money and more recipients but insufficient additional funds to support what those additional recipients traditionally absorbed. The numbers in parentheses in table 17 describe the level of state funding in 1983 that equals the county's 1982 program responsibility. According to the numbers, state support for mental health programs in San Diego fell 26 percent in real terms between 1981 and 1983. County financial outlays increased 45 percent after inflation, bringing the real decrease in overall funding to 13 percent.

TABLE 18

DETROIT (WAYNE COUNTY) BUDGET FOR MENTAL HEALTH PROGRAMS, STATE FISCAL YEARS 1981–83

(Thousands of Dollars)

Item	*1981*	*1982*	*1983*	*Percent Change, 1981–83*	
				Current Dollars	*Constant Dollars*
Medicaid					
Federal	668	904	1,137	70	54
State	668	904	1,208	81	63
State Department of Mental Health	26,415	27,575	31,649	20	8
County	3,009	3,164	3,643	21	9
SSI from recipients	2,533	2,434	1,386	44	30
Recipient fees and insurance			2,266		
Other[a]	13,314	14,763	12,188	−8	−17
Total	46,607	49,744	53,477	15	4

SOURCE: Data supplied by Detroit (Wayne County) Community Mental Health Board. Actual expenditures. Figures are rounded.

a. Includes miscellaneous grants and grantee or contractor income from numerous sources.

TABLE 19

RICHMOND BUDGET FOR MENTAL HEALTH PROGRAMS, STATE FISCAL YEARS 1981–83

(Thousands of Dollars)

Item	*1981*	*1983*	*Percent Change, 1981–83*	
			Current Dollars	*Constant Dollars*
Federal	...	...	...	...
State	1,044	1,285	23	11
City	1,423	1,274	−10	−19
Other and local	210	40	−81	−83
Fees	408	237	−42	−48
Total	3,084	2,837	−8	−17

SOURCE: Richmond Department of Mental Health and Mental Retardation budget documents. Figures are rounded.

Only Detroit (Wayne County) experienced an after-inflation increase in funding for mental health programs. Table 18 shows that this increase came partly from increased fee and insurance income, partly from switching charges for services to Medicaid where possible, and largely from increased levels of state support.

TABLE 20

BOSTON (REGION VI) BUDGET FOR MENTAL HEALTH PROGRAMS, STATE FISCAL YEARS 1981–83
(*Thousands of Dollars*)

Item	*1981*	*1982*	*1983*	*Percent Change 1981–83*	
				Current Dollars	*Constant Dollars*
Federal	1,188	1,185	1,219	3	−7
State	28,901	32,384	24,347	−16	−24
Total	30,089	33,569	25,566	−15	−23

SOURCE: Massachusetts Department of Mental Health budget documents. Figures are rounded.

TABLE 21

CHRONICALLY MENTALLY ILL CASELOADS OF PRIMARY MENTAL HEALTH AGENCIES IN SAN DIEGO, DETROIT, AND RICHMOND, STATE FISCAL YEARS 1981–83[a]

Site	*1981*	*1982*	*1983*	*Percent Change, 1981–83*
San Diego	148,857	153,334	158,107	6
Detroit (Wayne County)	15,280	15,934	20,138	32
Richmond	550	550	650	18

SOURCES: Agency records from respective sites. San Diego data are based on units of service (*not* counts of recipients) for all adult patients. Services include all twenty-four-hour residential care, all partial day, and extended care program outpatient recipients. They exclude outpatient clinic hours, which few chronic patients use. An unknown portion of these service units went to acute rather than chronic patients. The Detroit (Wayne County) data are based on a formula whereby number of adults equals 0.67 of the total direct caseload, and chronically mentally ill equals 0.75 of the adult caseload. The figure for 1981 is derived from an earlier and less-detailed data system. Data for Richmond are from verbal estimates of the administrator of the Day Treatment Center. The program there has no reliable data on unduplicated recipient counts for the years of interest. Figures are rounded.

a. Data for unduplicated counts or units of service are not available for Boston.

Caseloads

Informative as these budget figures are about what has happened in the four selected cities, the picture is not complete without a description of what happened to agency caseloads during the period studied.

Table 21 presents the best available data on caseloads in three of the four cities. San Diego was able to provide units of services but not unduplicated recipient counts. Detroit (Wayne County) provided unduplicated recip-

ient counts. Richmond had only the agency director's estimate of persons served before and after a reorganization of the agency in 1983. Boston had no reliable data on either units of service or unduplicated recipients.

All three cities reporting caseload data show increases in services and recipients between 1981 and 1983; in two cities these increases are substantial. Detroit's 32 percent increase in recipient caseload more than offsets the 4 percent real growth in its budget. Richmond's 18 percent client increase in recipients accompanies a 17 percent decrease in purchasing power. San Diego's service unit counts are up 6 percent, and this figure includes services to persons who once received care under California's now-defunct state program for medically indigent adults.

Agency Service Structures and Populations Served[6]

In each county visited a single agency had primary responsibility for programs and services for the chronically mentally ill. This agency provided direct services in three counties and purchased many services from a variety of private providers in all counties. In every county the primary agency also helped people obtain financial assistance and other services for which they were eligible from other government agencies.

San Diego

San Diego County's Department of Health Services operates or contracts for a full range of mental health services. The county has its own ninety-two-bed psychiatric hospital. It operates an Extended Care Program that oversees approximately 2,400 chronically mentally ill clients. It operates and also contracts for partial day programs, twenty-four-hour crisis care, twenty-four-hour long-term care, and case-management services. Under contract to the Department of Health Services, the state Office of Mental Health and Social Services provides case management for about 500 voluntary (chronically mentally ill) clients. The conservatorship program of the County Department of Social Services oversees another 1,800 people with mental health problems, and a contract agency has case-management responsibility for another 900 people a year who are primarily elderly and experiencing confusion and other mental problems associated with aging. Most of this group (85 percent) have never had a psychiatric hospitalization. In addition to services for the chron-

6. Readers who are not concerned with the detailed service structures in the four jurisdictions might want to skip to the next section.

ically mentally ill, San Diego's Department of Health Services purchased outpatient therapy services for adults at the rate of about 66,000 hours in fiscal 1983 and provides another 30,000 hours in its own clinics. Almost no chronically mentally ill use these therapy services. The agencies with major responsibility for the chronically mentally ill seem to communicate with each other regularly and to understand the services each provides.

About half the people participating in San Diego's Extended Care Program live in board and lodging homes, as do a significant number of persons served by the state Office of Mental Health and Social Services. Some extended care recipients and many conservatorship recipients live in nursing homes.

The Income Maintenance Division of the Department of Public Welfare makes SSI and Medicaid eligibility determinations. All persons served by the state Office of Mental Health and Social Services are SSI recipients; the same is true for about half of extended care patients. Almost none of the contract agency's elderly clients with mental complications receive SSI, although many receive Social Security payments and Medicare. Conservatorship recipients have mixed sources of income. Of clients not receiving SSI, many obtain general relief from the county and get medical care from programs for the medically needy or medically indigent adults, also administered by the Department of Public Welfare. Relations between the Income Maintenance Division and the mental health agencies are more adversarial than cooperative. Many of the mental health agencies assist in their recipients' appeals for the Income Maintenance Division's decisions on SSI eligibility.

Detroit (Wayne County)

The Detroit-Wayne County Community Mental Health Board (DWCCMHB; hereafter DWB), administered jointly by the city and county, funds over forty mental health agencies throughout Wayne County, seven of which are comprehensive community mental health centers. The Detroit-Wayne County Board uses state funds from the Michigan Department of Mental Health to purchase all direct services by contract. Seventy percent of the services are provided in the city of Detroit.

The DWB agencies provide three basic categories of services for the adult chronically mentally ill: outpatient services and aftercare, day hospitalization, and placement in residential care programs and follow-up case management. Among the DWB agencies are the county's seven comprehensive community mental health centers. The centers provide outpatient services, aftercare, and day hospitalization, as well as inpatient care, consultation and education, and crisis and emergency services.

In Detroit virtually every state-supported mental health agency in the county is under contract to the centralized DWB, so we can estimate the size of the population that receives some type of community-based mental health services. According to DWB, their forty-four agencies gave direct services to approximately 30,000 clients in fiscal 1980, 32,000 in fiscal 1981, and 40,000 in fiscal 1982. Two-thirds are mentally ill adults. The remaining recipients are mentally retarded adults and children or mentally ill children.

Of the mentally ill adults, about 75 percent are chronically mentally ill, and 25 percent are nonchronic—that is, either first episodes or emergency crisis cases involving drinking, battering, attempted suicides, police referrals, and so on. This latter category is said to be growing, a trend that is widely attributed to unemployment and layoffs. Almost all chronically mentally ill adults who receive community mental health support services show up in these figures; the only exception is the chronically mentally ill who seek care only through private physicians, psychologists, or social workers.

The DWB total recipient population is approximately half female and half male, and is made up of 46 percent white and 48 percent black recipients. Most are persons with low income and many receive Social Security payments or other forms of public assistance. Many of the chronically mentally ill adults have been deinstitutionalized after long stays in Northville, a large state psychiatric facility in Wayne County, and others have been in and out of Northville and other nearby state institutions (part of the often-described "revolving door phenomenon"). According to the DWB staff, the chronically mentally ill who have *never* been institutionalized, including a number of "street people," are least likely to be in the board's population because most placements in community support services occur at the time of discharge from hospitals. Approximately 70 percent of the people served by DWB agencies are solely outpatient and aftercare patients. Another 25 percent are enrolled in day hospitals, and 5 percent live in over 400 community-based residential care facilities where they are placed and supervised by two contract agencies.

The Michigan Department of Social Services, Wayne County Area Office, administers the SSI and Medicaid programs for Wayne County residents.

Richmond

The Department of Mental Health and Mental Retardation is the city agency responsible for providing community support services to deinstitutionalized mentally ill adults. Community services and case management are provided through agencies under contract with or managed by the Richmond Community Services Board. Established in 1968 by state statute, the board has responsibilities for planning, implementing, and reviewing all public

mental health, mental retardation, and substance abuse services and facilities in the city. Private services and facilities that receive state or federal funds also come under jurisdiction of the board, and the board appoints and supervises the director of the Department of Mental Health and Mental Retardation.

The department funds a mental health center that serves deinstitutionalized chronically mentally ill adults primarily through day support, case management, and medication maintenance programs. It is also the agency's responsibility to provide predischarge planning for city residents leaving state institutions. Chronically mentally ill services are housed in a day treatment center. Approximately one-third of the chronically mentally ill recipient population is involved in socialization or rehabilitation programs, day hospital, and stabilization. Some of these persons and others are in group therapy (approximately one-half of the total caseload of 600 to 650). Others are maintained in their homes through medication maintenance services.

There are no specific residential programs in Richmond for the chronically mentally ill. Most live in licensed adult homes. Those unable to qualify or requalify for SSI live in rooming houses. Few live with their own families.

Eligibility determinations for SSI are made by the Department of Rehabilitation Services. There is consensus and considerable dismay among staff and administrators of mental health services that eligibility criteria are being tightened at the expense of the chronically mentally ill.

Boston (Region VI)

Services for Boston's chronically mentally ill population are administered through the State Department of Mental Health. Massachusetts is divided into forty-one mental health catchment areas within seven geographical regions. Region VI, which includes the Boston area, has six community mental health centers serving various communities in greater Boston. Each of these community centers is associated with a medical center and also subcontracts or provides outreach activities and community programs to local agencies. In each region there are also state hospitals that provide inpatient backup facilities for acute and long-term care.

Boston area community mental health centers provide a broad range of services for chronically mentall ill adults, including nonresidental and outpatient treatment programs (emergency services, day hospitalization, day activities, day treatment) and residential treatment programs (inpatient care, group homes and apartments, foster care, and emergency shelters).

Each of these centers is responsible for providing or arranging for all the care its patients receive. Their programs are different, because each has

been relatively autonomous in developing programs and services. Some have had a good deal of federal funding in the past, whereas at least one had just applied for a federal initial operations grant in 1980 and never received it. Although Region VI is an official Massachusetts Department of Mental Health designation, in effect, each community mental health center operates as a separate, independent entity within its own geographical boundaries. There is little or no crossover of clients or services. Because of this situation, statistics for the entire Boston area are difficult to obtain and one cannot get a clear picture of mental health services in Boston. To determine the service delivery system in Boston, we therefore selected two of the six community mental health centers for more detailed interviews and data collection. These two centers are the Massachusetts Mental Health Center, which serves a catchment area approximately twice the size of the other Boston centers, and the Dorchester Mental Health Clinic.

Housing options for the chronically mentally ill in Boston depend to some extent on which center serves them. Some centers have developed quite elaborate community residential programs, including boarding homes, adult foster care, and apartment living. Individuals in these living situations receive case management and supervision from the respective center staff and participate in coordinated day programming at the center. Other centers do considerably less to assist their patients with life in the community.

At Massachusetts Mental Health Center, one of the two Boston community mental health centers whose staff we interviewed, they estimate they have approximately 600 admissions to inpatient care each year, representing 300 to 400 individual clients. They also estimate they have 38,000 outpatient visits a year, probably to no more than 1,500 persons, many of whom are the same persons admitted periodically to the inpatient services. Their population is approximately half female and half male, and is made up of 75 percent white and 25 percent nonwhite recipients. The majority are of low socioeconomic background; about 65 percent have incomes of $5,200 or less, and most have very little formal schooling.

The Dorchester Mental Health Clinic did not have equivalent data on its patients. However, staff there indicate the patients are of two primary types: middle-age or older white clients who were institutionalized at a nearby mental hospital and who have remained in the area, and younger patients in their twenties who are members of ethnic minorities. Dorchester is a federally designated poverty area with a high rate of unemployment and poor services.

The Department of Public Welfare administers the SSI and Medicaid programs. SSI eligibility determination and redetermination actions have put the community mental health centers into an adversarial relationship with the department in many instances.

Impact of Budget and Program Changes

Budget and caseload numbers can provide only a small amount of information about what has really happened to services in a community. It is even more difficult to capture a sense of what has happened to patients in the face of numerous changes in different programs. For each community visited, we summarize our findings below based on interviews with case managers, service providers, funders, and advocacy groups.

San Diego

The chronically mentally ill in San Diego have suffered significant cutbacks in care and financial support due to both federal changes and to state financial difficulties. The changes having the greatest effects are SSI eligibility determinations and MediCal rule changes, which appear to be motivated by the need to reduce costs as much as possible in the short run.

Community mental health services in California are funded largely by state and federal money. State money is authorized under the Lanterman-Perris-Short Act of 1968. (This act replaced the earlier Short-Doyle Act of 1957; the money is still referred to as Short-Doyle funding.) The county match for this funding is only 10 percent. MediCal, Medicare, and Supplemental Security Income (SSI) augment community mental health dollars for many chronic adult patients.

For the 4,700 clients in San Diego's Extended Care Program, the state Office of Mental Health and Social Services program, and the conservatorship program, SSI efforts to purge the rolls have greatly affected their well-being. One way to prove one's disability to SSI workers is to be rehospitalized, and many have taken this route, if only because the tension associated with uncertainty is enough to destabilize them. Many chronically mentally ill persons have not understood the notices they receive from SSI, and so have let appeal dates and hearing dates pass by. Only when the checks stop coming do they realize what has happened. Once without SSI, former recipients can only turn to general relief or the streets. The general relief fund in San Diego pays only $310 per month; SSI plus the State Supplemental pays $452 per month plus $50 spending money if the recipient lives in a board-and-care facility. (Most states supplement federal SSI payments up to an amount that will provide room and board in a board-and-care facility.) Board-and-care rates are geared to SSI payments; thus the decrease to general relief rates often means the recipient cannot continue to live in the boarding house. The frequent alternative is the street, and caseworkers report that more and more of their chronically mentally ill clients are forced to take this alternative.

For those who still retain their SSI eligibility, MediCal has begun to use a new method to calculate income available for medical care, using the general relief fund payment of $310 as the base rather than the SSI payment of $452. This means that recipients who once were expected to pay for medical care with only the $50 discretionary money they receive every month are now assumed to have $192 per month available for medical expenses (the difference between $452 and $310, plus the extra $50). In fact recipients do not have this money, since their residential care (board-and-care homes) costs $452 per month. Their choice comes down to housing or medical care.

The 900 or more mostly elderly clients receiving case management from a contract agency have other problems due to changes in federal regulations. These people largely suffer from confusion and other mental problems associated with aging. The majority do not receive SSI. The picture for them is complicated by changes in MediCal and Medicare regulations that spell the difference between chronically mentally ill clients receiving medical care or not.

Until 1982 MediCal picked up the copayment that Medicare required of elderly recipients. It no longer does so. For hospitalization the copayment is $304. Many chronically mentally ill elderly recipients do not have this money and hence forgo medical care they received under the old regulations. The $75 copayment requirement for outpatient care has the same effect.

If the patient does receive the care, outpatient or inpatient, and then cannot pay, Medicare is aggressively using promisory notes and liens on property and estates; such actions tend to frighten patients and prevent them from seeking the care they need. This point and the copayment requirement affect the near-poor who do not receive SSI. They also affect all the low-income elderly discussed in subsequent chapters.[7]

Poor, mentally ill people seeking MediCal assistance for the first time are affected by the changes. Because of new MediCal ways of counting assets (nonliquid assets like burial plots and life insurance policies that were previously disregarded are now counted), there is no guarantee that patients will qualify for MediCal even if they spend all their available money on health care before they apply.

Pressures from MediCal also threaten the Extended Care Program. This program supervises approximately 2,400 chronically mentally ill clients, as mentioned above. Teams made up of a psychiatrist, a nurse, and a clerk visit clients in 28 clinic sites for medication management and supervision. Many of these clinics are held in the board-and-care homes where the clients live.

7. See chapters 7 through 9 of this volume.

San Diego previously certified these clinics as part of MediCal and billed MediCal in a lump sum for the care delivered. MediCal is now increasing the certification requirements in such a way that San Diego may have to close down a large part of this very efficient operation. The care that MediCal will pay for hereafter will be more expensive and there will be less of it.

San Diego's spending for the chronically mentally ill remained the same from fiscal 1981 to fiscal 1983, but this includes a $2.7 million increase because of changes in the medically indigent adult program. During the last two fiscal years San Diego has cut $2.74 million worth of programming, closing or reducing 14 outpatient, partial-day, and socialization services, all but one for adults. The total community mental health budget is around $22 million, of which approximately 75 percent is spent on adults for all types of care. The chronically mentally ill have thus been hard hit by federal changes, especially regulatory changes, and will not receive compensatory services or support from San Diego.

Detroit

According to staff at the Detroit-Wayne County Community Mental Health Board (DWB), the mental health services the the board funds have not been substantially reduced over the past three years. In fiscal 1981 the state cut the board's funds by 10 percent, a cut that was absorbed by reducing salaries and benefits to employees. Since then, the state funds to the board have remained constant. By and large, the chronically mentally ill in the Detroit area have not been hit with substantial cutbacks, since the DWB has managed to keep its funding relatively constant to the agencies with which it forms contracts. (Most of these forty-four agencies receive the vast majority of their funds from the board, although they are required to raise at least a 10 percent match on their own). The only noticeable change that the DWB has implemented is a shift in funding away from some recreational ("non-therapeutic") facilities into emergency services and more therapeutic, professional services, such as day hospitalization. The DWB terminated a few purely recreational day activities programs; and the staff do not know whether these facilities replaced the lost funding or closed their doors.

Staff from the statewide Mental Health Association in Michigan—a private nonprofit United Way agency that advocates, organizes, and lobbies on mental health issues—painted a markedly less optimistic picture than did the DWB staff. State funds and caseloads in the past few years in the Detroit area have been relatively constant, but the demand for services has escalated greatly. As a result, the number of unserved people has risen sharply. The large influx of people seeking services is a function of stressful times—

extremely high unemployment and layoffs due to the recession. The result is an increase in requests for mental health services from a nonchronic population, many of whom need emergency intervention. Federal cuts in dollars to community mental health centers exacerbate the problem.

Increasing nonchronic cases are also noticeable at Northville, the state-run inpatient facility in Wayne County with a current population of 1,100, where the number of admissions has actually grown despite the statewide deinstitutionalization policy. Many informants in the Detroit-Wayne County area mentioned their perception that the rising demand for a whole range of services has resulted in *less* care for chronically disabled clients in order to meet the crises experienced by those who do not traditionally use the mental health system. The less immediately disabled recipients (people who have no immediate, pressing need, although they have chronic problems, including many chronically ill) are being displaced by those experiencing acute psychotic episodes. As a result, community-based services are even further taxed by the increased severity of their patients' conditions. Furthermore, prevention programs are being tightened to free funds for more direct services such as aftercare programs.

Local agency staff confirm this pattern. At Community Case Managers, a contract agency that places the chronically mentally ill in adult foster care, the staff sees few of the new type of patient (the crisis patient who is troubled by layoff or unemployment) because such clients rarely use adult foster care. However, because of the continuing deinstitutionalization of the chronically mentally ill from all hospitals in Michigan, this agency has had a three-fold rise in caseload, from 400 in 1980 to 1100 in 1982, with more than 1,200 expected in 1983. The rise in caseload has been coupled with a slight decrease in funds from the DWB. The decrease has been absorbed by freezing salaries and benefits; by shifting staff from case management to placement, thereby reducing the intensity of the service each patient receives; and by eliminating the aftercare program for patients who leave adult foster care for independent living. The staff believes this has led to higher rates of rehospitalization.

Providers of foster care for adults have also absorbed recent cutbacks. Many patients have lost their SSI and have switched to general assistance. As a result, they can no longer pay as much for room and board. Although the providers are expressing dissatisfaction, patients are rarely turned out when they lose their SSI. Adult foster care facilities have maintained their numbers, but many have closed and have been replaced by new providers with less experience dealing with the chronically mentally ill.

The situation at the state level is similar to that in Detroit. In 1979 the Department of Mental Health developed a comprehensive written plan to use case managers across a broad continuum of care, from inpatient hospital

settings to independent living. This whole plan was abandoned in the early 1980s and now virtually no outreach exists anywhere to those living independently.

The State Department of Mental Health staff estimates that, in Michigan due to the statewide pressures on the mental health system, 36,000 people seeking mental health services were turned away in 1983. In contrast, almost every person in the state who sought care three years before was served. Now in most areas only the most severely in need actually receive services.

Richmond

The Department of Mental Health and Mental Retardation, which has primary responsibility for Richmond's chronically mentally ill, has not been directly affected by federal retrenchments and changes. It has been faced with cutbacks closer to home, particularly at the local level. Hardest hit by these cuts was the Mental Health Services Division, which went through a major consolidation effort in order to avoid staff reduction. Administrators feel confident that the consolidation effort actually improved services to city residents with mental health needs. According to the staff and the administration, the deinstitutionalized chronically mentally ill are receiving higher quality services than before reorganization. These same staff members and administrators both are quick to note, however, that deinstitutionalized adults are feeling the effects of changes in income maintenance, Medicaid, and other secondary support services that enable them to remain in the community.

Mental health services underwent major changes in fiscal 1983. As of July 1982 the acute care inpatient unit housed in a local hospital was closed and six neighborhood clinics (four outpatient, one day treatment, one acute care) were consolidated into one downtown facility. These actions were taken in response to an anticipated fiscal 1983 loss of $361,000 in city funds compared to fiscal 1982 levels. Even maintenance of fiscal 1982 funding, according to mental health administration calculations, would have resulted in a $73,000 deficit if staffing and services had been kept constant.

In addition to this expected revenue loss of 20 percent of the personnel and operating budget for fiscal 1982, mental health services faced further reductions in the following fiscal year because of changes in pay scale for city employees. Personnel costs jumped from $1,200,000 in fiscal 1982 to $1,865,000 in fiscal 1983—a 54 percent increase. Concomitantly, operations money fell from $918,000 to $704,000—a 23 percent drop.

The above-mentioned consolidation into one downtown facility occurred at this time because the agency anticipated reduced city funds. However, plans to consolidate had "been on the back burner" for several years. The

existing system was always supported solely with state and city funds. Staff and administrators say that because of poor staffing patterns, the previous decentralized system was ineffective and inefficient. Caseloads were high (75 to 100 per staff member), specialized staff had to be generalists, outreach was impossible. By all reports, the reduction in city funds was a blessing in disguise because it finally forced the Mental Health Committee to act.

Maintaining chronically mentally ill adults in the community requires an array of support services. In addition to special programs that develop social skills or prepare these adults for some form of employment, deinstitutionalized adults require a variety of community-living support—income, housing, food, personal care, and transportation assistance. In Richmond it is this second category of services and support that has been directly affected by federal program changes.

The effects of SSI changes have already been mentioned. With respect to housing, Richmond has no special residential programs or housing supplements for chronically mentally ill adults. These adults live primarily in licensed adult homes; those who are unable to qualify or requalify for SSI live in rooming houses. Chronically mentally ill adults are much less likely than mentally retarded adults to be living with families. They are a much more transient population.

One of the supports that caseworkers once relied on to meet emergency housing needs for the chronically mentally ill—church assistance—is now difficult to obtain, according to the Mental Health Center's chief caseworker. Churches that once offered food and housing assistance to chronically mentally ill clients are low on funds. Many have earmarked their remaining dollars for church members because of increasing demands.

The number of licensed foster homes for adults in Richmond appears to grow to meet demand. The quality of these homes, however, is suspect. The director of the Virginia Mental Health Association said that one of the main goals of the association is to "clean up these places." A bill is being introduced in the state legislature that will define the rights of residents of these licensed homes. The chronically mentally ill, for the most part, are in homes where bed space has not been filled with elderly persons. The chronically mentally ill are not the preferred residents.

Boston

According to the staff of the State Department of Mental Health, the mental health budget for Massachusetts has not been greatly affected by federal funding cutbacks. This is because in most of the affected community mental health centers in the state had completed the cycle of their eight-year federal

grants by fiscal 1982. In anticipation of this event, the state had replaced most of the expiring federal funds through appropriations.

However, the block-grant legislation brought about a significant shift of power in community-based mental health services. Before the block grant, community mental health centers functioned as semiautonomous agencies and received funding directly from the federal government. Block-grant funds now go instead to the Department of Mental Health's area offices for distribution. In fiscal years 1982 and 1983 all the funds were distributed to center programs that had held operations grants and would have received the money directly under previous federal procedures. In the future, however, it is possible that a third of block-grant monies will go to area offices to be distributed through a proposal mechanism to those bidders deemed most responsive to area service needs and priorities. This means that the centers might absorb an additional cut in block-grant funds, which would result in a further reduction in the provision of community mental health services through the centers.

According to the Massachusetts Human Services Coalition:

> Although it is generally acknowledged that the cuts resulted in lost services, there seems to be some disagreement about the degree of hardship. On one hand, it is argued that the planning process will be enhanced by combining state and federal funds, that community services can be more fully integrated into the area-wide planning process, and that Community Mental Health Centers can be held accountable for delivering services to the most severely disturbed clients. On the other hand, it is claimed that the shift from federal prospective payments to state retrospective payments (resulting in a funding gap of up to three months), the state's cumbersome voucher system and the potential loss of eligibility as Community Mental Health Center result in program inefficiencies that compound lost federal revenue.[8]

The impact of federal changes on specific community mental health agencies serving the chronically mentally ill, can best be seen by first taking a close look at the Massachusetts Mental Health Center, one of six community mental health centers serving the Boston area. Chronically mentally ill adults enrolled in this center's residential treatment programs appear to be the ones most affected by recent federal program changes. These deinstitutionalized adults require long-term care. Many who are dependent on SSI have been hit hardest and have been most vulnerable to changes in available support services. Between 1981 and 1983 there has been a dramatic increase in the number of chronically mentally ill clients who have been denied SSI benefits or have had their benefits reduced. Eligibility has been tightened by a more

8. Massachusetts Human Services Coalition, *Analysis*, p. 21.

rigorous criterion to qualify as chronically mentally ill. The criterion calls for extensive medical documentation that is highly specific about prognosis, the time frame of the illness, and the degree of impairment. The Massachusetts Mental Health Center has introduced training sessions for staff doctors to teach them how to write medical histories that will satisfy SSI requirements. The center's staff explained that while it has been generally successful in appealing the SSI denials, the process is a lengthy one and causes undue stress on chronically mentally ill patients.

The center staff reported they have stopped sending new applicants to the SSI office, since experience has shown that it is a waste of time for their chronically mentally ill clients to apply. (Caseworkers in other cities reported equal levels of frustration.) The staff also reported that state monies for general assistance have simultaneously been tightened and that consequently less emergency income-maintenance funding is available for the chronically mentally ill. Because of this and the prevalence of area unemployment, increasing numbers of chronically mentally ill are unable to pay $200 a month for room and board in group residences.

The Massachusetts Mental Health Center is part of a state mental hospital as well as being a community mental health center, so it has two different organizational systems and funding sources. As a psychiatric teaching hospital for fifty years, this center has always had a steady source of funding through which it offers an extensive, comprehensive program for chronically mentally ill adults. Federal grant requirements for community mental health center activities have been met by adding services through federal community mental health center funding, while basic continuing-care services have remained the same. However, block-grant implementation and declining state funding have increasingly forced the center to serve only the "sickest" or the most severely disturbed clients. Outreach, consultation and education, prevention, and community activities and services have been cut or deemphasized. Now people who are not severely disabled are less likely to receive services.

Federal changes to the alcohol, drug abuse, and mental health block grant have had a more direct effect at the Dorchester Mental Health Clinic than they have at the Massachusetts Mental Health Center. Dorchester has been in the unique position of experiencing the full impact of the alcohol, drug abuse, and mental health block-grant implementation and federal cutbacks. The Dorchester clinic applied in 1980 for a categorical initial operations grant as a community mental health center. The request was rescinded, converted into a block-grant request, and the money was subsequently allocated through the state rather than given directly to the clinic by the federal government. The Dorchester clinic's block-grant allocation was one-fifth to one-sixth of what it originally requested. The block-grant legislation affected

anticipated services, which had a high probability of receiving federal support before the Reagan administration created the state-administered block grant. To develop residential programs, Dorchester had applied for funds to develop half-way houses and cooperative apartments to provide transitional, independent living situations for chronically mentally ill adults in its catchment area. Without federal funds, Dorchester could not implement this program.

The Dorchester clinic had planned a major expansion in emergency services that would have created fifteen staff positions and increased programs to minimize hospitalization. This expansion of emergency services was canceled due to funding cutbacks. Finally, to meet community needs, Dorchester had planned to expand services to include alcohol and drug abuse and senior services components; these plans were also canceled because of insufficient funds.

Summary

Federal changes in funding specifically earmarked for community mental health centers do not appear to have made a great deal of difference for agencies serving the chronically mentally ill. In most cases local or state changes in funding levels have had the biggest influence. In two states, California and Massachusetts, these local and state changes have been driven by relatively more conservative government philosophies than in previous years, backed up by referenda constraining public revenue activities. Proposition 13 in California, Proposition $2\frac{1}{2}$ in Massachusetts, and Proposition J in San Diego all constrain revenue-raising actions (the two state propositions) or total budget growth (San Diego's Proposition J). Michigan's budget problems at the state and local level are overwhelmingly due to the troubled automobile industry and its effects on the economy and employment in Detroit and elsewhere in the state. These conditions have also exacerbated mental health problems at a time when the state does not have the financial resources to meet them in a manner consonant with its generally liberal philosophy of government. All jurisdictions in this study except Boston also reported funding difficulties as a result of the recession—a recession that brought both reduced revenue and more need for services in the mental health area (and in many other areas).

In all jurisdictions the federal changes most seriously affecting the chronically mentally ill were the changes in SSI operating procedures. The precise nature of these changes was neither legislatively mandated nor subjected to normal rule-making procedures. Rather, the Social Security Administration issued detailed changes in its policy manual that affected SSI eligibility de-

cisions for both new applicants and continuing recipients, as discussed in chapter 5.

The Social Security Administration maintains that continuing disability reviews pertain only to recipients of Social Security Disability Income (SSDI) and to people who receive both SSDI and SSI. Those who receive only SSI should not be affected by these reviews of cases. However, somewhere between the Social Security Administration's official intent and the local disability determination offices these restraints appear to have been lost. In every city we visited there were many instances of people who received only SSI, whose cases were called up for redetermination hearings, and who were dropped from the SSI rolls as a result.

No one in any of the cities we visited had concrete numbers for the magnitude of the SSI problem, yet everyone felt it was the most significant change in federal policy affecting the people who use SSI services. We can make some estimates of the numbers of chronically mentally ill adults affected by SSI changes if we are willing to make some assumptions. In chapter 5 we estimated that there are 1.7 million chronically mentally ill adults in the United States. Assume first that approximately half of these people receive services from some mental health agency at any given time. Then assume that approximately half of these persons also receive SSI (this assumption is derived from our local interviews). Assume further that approximately half of the SSI recipients are called for a redetermination hearing, and that approximately half of those hearings result in termination of SSI benefits (this assumption is based on local perceptions and on research).[9]

According to these assumptions, approximately 106,000 chronically mentally ill former SSI recipients will lose their benefits, at least temporarily, as a result of redetermination hearings under new federal procedures. This figure represents approximately 12 percent of chronically mentally ill SSI recipients. We add the proviso, "at least temporarily," because many of these recipients of SSI who have caseworkers in mental health or other service agencies have filed appeals of these redetermination decisions. Initial negative eligibility determinations are being reversed about 65 to 67 percent of the time if they are appealed. State and county officials perceive the importance of helping SSI recipients with appeals both because they see the human cost involved in lost SSI benefits and because they know that state and local welfare dollars will eventually have to assist the chronically mental ill when

9. See P. Michel, *The SSI/SSDI Disability Controversy* and *Social Security Disability Benefits Terminations: New York*, Hearing before the Subcommittee on Retirement Income and Employment of the House Select Committee on Aging, 97th Cong., 2d sess. (Washington, D.C.: U.S. Government Printing Office, July 1982), committee publication 97-353.

they (and other recipients of SSI) lose those SSI benefits.[10] All officials with whom we spoke expressed concern for people on SSI who do *not* have caseworkers to help them with the appeals process. Undoubtedly, many of the failures to appeal SSI decisions arise not because of the merits of the case, but because the paperwork and bureaucratic expertise one must have to prevail and win an appeal are enormous and often are well beyond the coping ability of the chronically mentally ill.

To conclude, the major impact of the Reagan administration on the lives of the chronically mentally ill has come about through regulatory or procedural changes, not through budget cuts or changes in administrative structure from categorical to block grants. These changes, particularly those in SSI and the Medicaid eligibility that goes along with it, have not been as highly published as the budget cuts. Nevertheless, their influence has been felt in every part of the system that serves the chronically mentally ill, all of whom report that losing SSI benefits is devastating to the well-being of these recipients.

10. Ibid.

PART THREE

THE LOW-INCOME ELDERLY

CHAPTER 7

WHO ARE THE LOW-INCOME ELDERLY?

The economic situation of the elderly has improved dramatically in the past two decades and has continued to improve during the Reagan administration. As late as the 1960s, poverty among older Americans was seen as a very serious concern. Data prepared for the delegates to the 1961 White House Conference on Aging showed that 6 million elderly (more than one-third of the population over age sixty-five) had inadequate income. Between 1960 and 1970 this number decreased to 5.7 million; the 1980s have seen it drop to under 4.0 million. Given that the number of persons over age sixty-five has increased 54 percent from 16.6 million in 1960 to 25.6 million in 1980, this decline in the number of elderly living below poverty is impressive.

The economic situation of the elderly has improved not only in absolute terms but in relative terms in recent years. In 1959, 22.4 percent of America's total population lived below the poverty line; more than one-third of those aged sixty-five and older, however, (35.2 percent) were among the impoverished (see table 22). As late as 1970 America's domestic policies were much more successful at reducing poverty overall than they were at addressing poverty among the elderly; the poverty rate for the entire population had fallen to 12.6 percent by this time, but poverty among the elderly was still quite common, with one out of four persons falling below the line (24.5 percent).

Federal actions during the 1970s (most specifically the indexing of Social Security to the consumer price index) significantly closed this gap. In 1981 the poverty rates for the total population and for the elderly were within two percentage points of each other: 14 percent and 15.3 percent, respectively. By 1983 this situation was almost exactly reversed. For the first time, older Americans were marginally less poor than those under age sixty-five.

The overall portrait of the elderly in the 1980s, then, is very different from that painted for the White House Conference on Aging twenty years

TABLE 22

POVERTY RATES AMONG THE ELDERLY, SELECTED YEARS, 1959–83
(*Percent*)

Year	Total Population	Under Age 65	Age 65 and Older
1959	22.4	21.1	35.2
1970	12.6	12.6	24.5
1980	13.0	12.6	15.7
1981	14.0	13.8	15.3
1983	15.2	15.3	14.1

SOURCE: U.S. Bureau of the Census, advance data later published in "Money Income and Poverty Status of Families and Persons in the United States: 1983," *Current Population Reports*, series P-60, no. 145 (Washington, D.C.: U.S. Government Printing Office, 1984).

earlier. Tremendous strides, mainly at the federal level, have been made in improving the economic conditions of the elderly. Consideration of these gains, in conjunction with recent deficit increases, inflation, and shrinking rather than expanding budgets for domestic programs has led some critics to argue that most of the elderly do not need more federal assistance. Rather, they contend that the time has come for a move away from *age-based* policies and legislation to *need-based* ones. Bernice Neugarten, a well-known scholar on aging, has become a very vocal advocate of need-based policies:

> Age-based legislation may have the eventual effect of denying services to those older persons who are most in need. By most estimates about 15 to 20 percent of people over sixty-five require some form of special health or social services. In a period of inflation and shrinking economic resources, when the public clamors for a curb on government spending, the worry is that this 15 percent may not be served adequately because it is being obscured by the other 85 percent in the age category.[1]

This concern—that services to the elderly who are heavily dependent on them may decline because of a perhaps misplaced desire to provide services to all elderly—coincides with the Reagan administration's general policy stance of trimming domestic spending by targeting resources more effectively to the "truly needy."

In this and the following two chapters we explore characteristics of the low-income elderly population, the history of federal involvement in efforts to reduce poverty among the elderly, and the effects of federal changes in the early 1980s. The chapter begins with a description of the low-income

1. Bernice Neurgarten, "Age or Need?" *National Forum* (Fall 1982), pp. 25-27.

elderly population, a population that in many ways is becoming very different demographically from the general elderly population. We then examine the special needs of the low-income elderly, both in comparison with the general U.S. population and with more economically advantaged elderly.

The Population of the Low-Income Elderly Defined

In 1980 an income of $3,949 for an older American living alone and $4,983 for an elderly couple placed them at the poverty line.[2] Almost 4 million persons aged sixty-five and older (15.7 percent of this age group) fell below this line. These low-income elderly were disproportionately women, minorities, the very old (age seventy-five and older, often referred to as the frail elderly), and elderly living alone or with unrelated individuals.

Table 23 shows the recent poverty rates among these subgroups. The poverty rates for these "vulnerable" individuals are higher than the general rate for all those aged sixty-five and older in every instance. When compared with their more affluent counterparts, these vulnerable subgroups present poverty rates that are 50 percent to more than 300 percent higher. Although only 8 out of 100 elderly persons residing with relatives experienced poverty in 1980 and 1981, 30 out of 100 of those living alone or with nonrelatives found themselves below the poverty line. Women were almost twice as likely as men to have inadequate income in 1981 and 1983. In 1983 black elderly persons were three times and Hispanic elderly about twice as likely as white elderly persons to live below the poverty line. The incidence of poverty was 50 percent greater among elderly persons aged seventy-two and older than among those aged sixty-five to seventy-one.

These disparities between vulnerable subgroups and the more well-off subgroups are disturbingly large, and it appears that they have grown over the past two decades. As the last column in table 23 shows, poverty among elderly whites, men, and family members has decreased 60 to 70 percent since 1959. Gains among the other subgroups, particularly the black elderly, are less impressive. Federal policies and legislation have improved the economic status of all older people, but the subgroups have not shared equally in the gains. As we discuss in detail in chapter 8, most of the income gains can be attributed to changes in Social Security payments (the Old Age and Survivors' Insurance provisions of the Social Security Act). Women, minorities, and, to a certain extent, single elderly tend to have had less permanent and less profitable attachments to the labor force during their preretirement

2. The poverty index is based solely on money income and does not reflect noncash benefits such as food stamps, Medicaid, and public housing.

TABLE 23

CHARACTERISTICS OF THE ELDERLY IN POVERTY, SELECTED YEARS, 1959–83
(*Percent of Elderly U.S. Population*)

Category	*1959*	*1970*	*1980*	*1981*	*1983*	*Percent Change, 1959–81*
All elderly (age 65 and older)	35.2	24.5	15.7	15.3	14.1	−60.0
White	33.1	22.5	13.6	13.1	12.0	−63.7
Black	62.5	48.0	38.1	39.0	36.3	−41.9
Hispanic	n.a.	n.a.	30.8	25.7	23.1	...
Women	35.6	27.5	18.5	18.6	17.0	−52.2
Men	34.7	20.2	11.1	10.5	10.0	−71.2
Residing with relatives	26.9	14.8	8.5	8.4	[a]	−68.8[b]
Residing alone or with nonrelatives	61.9	47.2	30.6	29.8	[a]	−51.9[b]

SOURCES: U.S. Bureau of the Census, *Statistical Abstracts of the United States, 1984* (Washington, D.C.: U.S. Government Printing Office, 1985), table 781. Note that in estimates of poverty for women, female heads of household and other female family members were combined to obtain the total number of women in families. Data for 1983 are from Bureau of the Census, "Money Income and Poverty Status" (Washington, D.C.: U.S. Government Printing Office, 1985).

n.a. Not available.

a. Not available by age.

b. Data are for 1959–81.

years. These groups, consequently, have benefited less from Social Security payment increases than have whites, males, and the elderly residing with relatives.

Characteristics of the Population: Trends

It is important to note that the elderly subpopulations most at risk of having low income are those segments of the total elderly population that are growing most rapidly. The number of Americans between ages sixty-five and seventy-four has doubled since 1950, rising from 8 million to 16 million in 1980. The number of frail elderly (aged seventy-five and older) has risen 150 percent during the same period, from 4 million to 10 million. Women and men were approximately equal proportions of the elderly population in 1950. By 1980 there were three elderly women for every two elderly men. The life expectancies for black Americans and Hispanics have begun to increase,

although the numbers of people in these groups over age sixty-five are still small in comparison with the number below age sixty-five. Between 1983 and 2030 the number of black elderly is estimated to increase by 329 percent, boosting the number of blacks in the elderly population from one in twelve to one in eight. The elderly population as a whole is expected to increase during the same period by 212 percent, and the percentage of elderly persons in the United States is expected to shift from 11.6 percent to 21.2 percent of the entire U.S. population.[3]

One of the most striking changes to occur during the past thirty years is in the living arrangements of the elderly. The situation for elderly men has changed little: in 1979, 83 percent lived with relatives (most with their wives); in 1950, the figure was 89 percent. Fewer elderly men are living with spouses now than in earlier years, but this decline has been offset by an increase in elderly men living with their grown children. Older women, on the other hand, are now much more likely to live alone than they were thirty years ago. In 1950, 19 percent of elderly women lived alone or with nonrelatives. By 1979 this figure had increased to 42 percent. In contrast with elderly men, older women are not being taken in by their children when faced with living alone. The percentage of elderly women living with spouses has remained stable since 1960, but the proportion living with children or other relatives has dropped from 23 percent to 11 percent.

Changes in labor force participation, pension plans, and general economic circumstances for women and minorities suggest that in future years these populations may be somewhat less "at risk" of being in poverty in their later years than they are now. Nonetheless, it is important to note that the subpopulations of elderly who have benefited least from the federal efforts occurring in 1980 or earlier are expected to make up an increasingly large proportion of the elderly population. Without major policy changes, it is quite likely that these subgroups at risk will constitute an even larger proportion of the low-income elderly population.

The Special Needs of the Low-Income Elderly

Older Americans in general face the dilemma of increasing health needs and decreasing income.

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3. U.S. Bureau of the Census, "Projections of the Population of the United States by Age, Sex and Race: 1983-2080," *Current Population Reports*, series P-25, no. 952 (May 1984).

Health-Related Needs

In 1979 the costs of health care for Americans aged sixty-five and older accounted for 29 percent of the country's health care expenditures even though the elderly made up only 11 percent of the population. Per capita expenditures for health among the elderly were almost three times higher than those of nonelderly adults during that year. At a little over $2,000, these expenditures represented over one-fourth of the average elderly person's income.[4]

Obviously the low-income elderly have no means of meeting these kinds of health care costs without assistance. If medical insurance or subsidized medical care are pressing needs for the majority of the elderly population, they are vital for the low-income elderly. Women, minorities, people living alone, and the frail elderly—the subgroups disproportinately represented in the below-poverty elderly population—have greater health care needs, as described below. In conjunction with their poverty status, these needs make them vulnerable and reliant on public help to obtain adequate medical care.

Women. Longevity, poor health, and lack of relatives to provide care have led elderly women to enter nursing homes in large numbers. In 1977 more than 70 percent of nursing home residents were women. The overrepresentation of women in the nursing home population is due mainly to the fact that there are more women in the upper-age brackets, the ages when health care needs are more acute.

Minorities. Minorities are underutilizers of health care services both before and after retirement age. As a consequence, they enter old age with more severe health problems and move through old age in relatively poorer health. A 1979 survey by the National Center for Health Statistics found that 31 percent of white elderly persons reported fair or poor health but 46 percent of the black elderly made similar assessments.[5]

Elderly Persons Living Alone. According to this 1979 survey, about one in six older Americans needs some assistance in getting around their house or neighborhood and about one out of eleven needs help with daily self-

4. The costs of nursing home care make up more than one-quarter of the per capita average for health care costs. Projections suggest that nursing home utilization and costs will be the fastest rising segment of the health care system in the next two decades, increasing about 49 percent, with 89 percent of the users being over age sixty-five. Nursing home costs tend to be concentrated among a small segment of the elderly population (only about 5 percent are nursing home residents) and thus should be used cautiously when estimating average health care expenditures. Factoring these costs out completely, however, still leaves the average American over age sixty-five with health care costs amounting to more than one-sixth of their income. See Carole Allen and Herman Brotman, eds., *White House Conference on Aging: 1981 Chartbook on Aging in America* (Washington, D.C.: 1981), pp. 92–93.

5. Ibid., p. 74.

care tasks (eating, bathing, dressing). Many of the elderly who live alone undoubtedly receive regular help from family and friends, but some must rely on help from public or private agencies or live in nursing homes in order to receive adequate care.

The Frail Elderly. Mobility impairment increases with age, as does the accompanying need for in-home assistance, nursing home stays, and hospital care. Three out of ten elderly persons between ages sixty-five and seventy-four were hospitalized in 1978, compared to five out of ten elderly over age seventy-four who received in-patient treatment during that year. In addition, hospital stays were usually longer among the frail elderly than among persons aged sixty-five to seventy-four.

Income Needs

The low-income elderly by definition have a greater need for income assistance than do other older Americans. It is useful at this point to discuss why. The low-income elderly differ not only in the amount of income they have at their disposal, but also in the sources of income. Low-income elderly are less likely to have earnings to augment retirement or SSI benefits than are higher-income elderly (0.9 percent versus 18.0. percent, respectively). They are also much less likely to receive income from dividends, interest, or rent (32.6 percent versus 73.6 percent). The low-income elderly are also less likely to have private or government pensions than are elderly at higher income levels (6.1 percent versus 32.6 percent).[6]

These differences in income sources between the moderate- and low-income elderly populations, when combined with the demographic differences outlined earlier (more women, elderly residing alone or with nonrelated persons, and so on), mean that the quality of life for low-income elderly is very much dependent on the availability and cost of a full spectrum of services and supports—from affordable housing and transportation to home-delivered meals, chore and homemaker services, and personal care. Lack of income makes fulfilling basic needs more difficult. Obtaining physically adequate housing in safe neighborhoods, food in sufficient quantities and of good nutritional value, heat and other utilities, and personal services if disabled are all made less likely by severe financial constraints. Rent increases, reductions in the availability of discounts for senior citizens on public transportation, bottlenecks in demand for public housing, increases in minimum charges for meals in senior citizen food programs, and similar changes in

6. Data in this paragraph are from U.S. Bureau of the Census, *Current Population Reports*, series P-60, no. 138 (1981) table 15.

other support services all erode the quality of life of low-income older Americans. Collectively, such reductions may jeopardize their ability to remain living independently. This group is both much more reliant on public support for income and much more sensitive to small changes in the quantity or costs of public supports and services than are more affluent older Americans.

Summary

Government action beginning in the 1970s substantially eased the poverty situation of many elderly Americans. Nevertheless, significant subgroups of the elderly—especially minorities, women, and people living alone—still suffer disproportionate levels of poverty. They have important, and often unmet, health, housing, nutrition, social service, and other needs that government programs have addressed to greater or lesser degrees. Chapter 8 describes the major federal initiatives to alleviate poverty and their effects on the elderly. It also reviews what has happened to those programs since 1981 when the Reagan administration took office and looks at how the income of elderly households has fared from 1980 to 1984. Changes in actual services for the low-income elderly are reviewed in chapter 9.

CHAPTER 8

FEDERAL POLICIES AND PROGRAMS FOR THE LOW-INCOME ELDERLY

The past two decades have seen dramatically increasing social welfare expenditures in the public sector. Federal expenditures have grown the fastest, rising from a third of the budget in 1965 to more than half of the budget in 1976. The greatest increases have been in health and income security expenditures—Social Security, Supplemental Security Income (SSI), Medicare, and Medicaid—programs that greatly benefit the aged. While a 1975 study by the General Accounting Office estimated that more than 130 federal programs affect the elderly, these four programs capture most of the federal activity on aging and account for virtually all the improvements that have been made in the economic conditions of the elderly in recent years.[1]

The first two sections of this chapter briefly review the development and effects of these four programs and four others that benefit proportionately large numbers of low-income older Americans—food stamps, housing assistance, Older Americans Act programs, and social services block-grant programs). The remainder of the chapter discusses federal outlays and changes under the Reagan administration and summarizes the network of programs benefiting the elderly.

Development of Policy for the Aging

It is important to note that public response to the elderly, while impressive, was slow to come. The first part of the century found the United States

1. U.S. Congress, House, *Government's Response to the Elderly*, Hearings before the House Select Committee on Aging, 94th Cong., 1st sess. (Washington, D.C.: U.S. Government Printing Office, November 20, 1975), p. 8.

well behind many other industrial nations in developing a policy for the aging. As Lammers in a recent book, *Public Policy and the Aging*, notes:

> When the delegates to the 1961 White House Conference on Aging met to review existing policies and propose new initiatives they had good reason to feel that their nation had given short shrift to the problems of the aging. A system of Social Security benefits was not established in the United States until 1935—much later than in other countries with a comparable level of socioeconomic development. In 1961 health costs still were not covered for the aging (or any other group) as a matter of right, and the expanding nursing home industry was receiving very little effective regulation. Social services for the aging existed only to a limited extent even in the most progressive states.[2]

In 1960 only 62 percent of retired workers were receiving Social Security benefits. At their maximum, these benefits were barely adequate for individuals relying on them as their sole, or even primary, source of income. The poverty threshold for a single person aged sixty-five or older was $1,397 in 1960. The *maximum* monthly Social Security benefit, $119, placed a retired worker just above this threshold with an annual income of $1,428. Retired workers receiving the minimum monthly benefit of $33 were obviously well below the poverty threshold if they were relying on Social Security as their primary income source. When one bears in mind that health care coverage was not generally available to the elderly and that social services were still in their infancy at this time, it is clear that many older Americans lived their lives on the brink of physical and economic disaster.

The 1960s and early 1970s—the heyday for America's social programs—saw a rapid expansion of interest and commitment to the elderly, most of which came about through amendments to the Social Security Act of 1935.

The 1965 Amendments to the Social Security Act

Medicare, Title XVIII. Building on the Kerr-Mills Medical Assistance Act of 1960 that utilized federal matching grants to expand medical assistance to the needy, Medicare (Title XVIII) was established in 1965 to make possible a national system of health insurance for the elderly. The legislation provided partial coverage of the costs of hospital and related care for Social Security beneficiaries aged sixty-five or older (Part A) and offered a voluntary contributory program, that is, paid for through monthly premiums, to help with the costs of physician services (Part B). By 1981, 96 percent of the population aged sixty-five and older had Medicare coverage. Virtually all these persons were insured under both the hospital (Part A) and supplemental (Part B) plans.

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2. William Lammers, "Public Policy and the Aging," *Congressional Quarterly*, vol. 40 (1983), p. 33.

The minimum cash outlay for persons paying their own premiums, deductions, and copayments was $132 in 1981.[3] This jumped to $336 for those hospitalized under sixty days during the year.

Medicaid, Title XIX. Medicaid, also established by the 1965 amendments, is a program of medical assistance for the needy administered by each state within broad federal guidelines. The federal, state, and local governments share the costs of assistance; the federal government pays approximately half. States must cover the "categorically needy," that is, persons receiving SSI or Aid to Families with Dependent Children (AFDC) and may also cover "medically needy" persons whose incomes are not sufficient to cover living expenses and medical costs. Under Medicaid, full or partial payment for inpatient and outpatient hospital services, laboratory services, skilled nursing services, and physician services must be made on behalf of all eligible beneficiaries. States may also opt to cover a wide variety of other services, including prescription drugs, eyeglasses, private day care, nursing, intermediate care facility services, physical therapy, and dental care. For the elderly, Medicaid essentially supplements Medicare coverage; at the state's discretion, Medicaid pays Medicare premiums, copayments, and deductibles and provides inpatient services that are not fully covered under Medicare (such as skilled nursing care and prescription drugs). In 1981, 12 percent of the elderly population (33 percent of those below the poverty threshold) received Medicaid coverage.

The Older Americans Act of 1965

In addition to these amendments to the 1935 Social Security Act, Congress in 1965 passed the Older Americans Act, which created a central administrative office, the Administration on Aging, within the U.S. Department of Health, Education, and Welfare. The purpose of this act was to make a comprehensive range of social services available to the elderly through the cooperation and partnership of community agencies and state and local governments. As it currently stands, the act authorizes funds for establishing state and substate agencies to plan and coordinate services, for professional training and research on aging, for developing work opportunities for the elderly through community service employment, and for delivering social and nu-

3. Beyond the monthly premium for supplementary medical insurance, Medicare recipients are required to pay a deductible for inpatient hospital care ($204 in 1981) and to copay for hospital stays beyond sixty days and for nursing home stays beyond twenty days. In 1981, 12 percent of the elderly had some or all of these expenditures paid by Medicaid. Many of those ineligible for Medicaid had private insurance policies to provide supplementary coverage.

trition services. Programs and services under the act are available to all elderly persons aged sixty years and older, without regard for income.

The 1972 Amendments to the Social Security Act

Supplemental Security Income, Title XVI. This amendment redirected primary responsibility for the aged, blind, and disabled from the states to the federal government, guaranteeing a minimum income level for all eligible persons. Eligibility is based on both a categorical requirement and an income test. Categorically, applicants must be age sixty-five or older or blind or disabled as defined by the Social Security Administration. Income limits have generally been set below the poverty threshold. In 1981 the income limit for an individual was $3,176, 73 percent of the poverty threshold of $4,360.[4]

States are required to supplement the federal SSI payments if the federal payment does not maintain the 1973 income level of recipients who were transferred from the federal-state old age assistance programs to SSI in 1974 when SSI payments began. In addition, states have the option of supplementing the SSI minimum level for all or selected categories of persons. In 1981 all states except Texas provided some supplementary assistance. Of the 1.7 million aged receiving SSI, in that year 650,000 (39 percent) received state supplements; 250,000 additional persons received state supplements even though they received no federal SSI payments.[5] Approximately 20 percent of SSI recipients classified as disabled are also elderly (age sixty-five and older). They receive state supplements in roughly the same ratios as those who qualify on the basis of age.

Indexing Social Security and Increases in Benefit Levels. Effective June 1975, Social Security payments (including SSI) were automatically indexed to the consumer price index, rising by the percentage of increase in this index whenever this increase is 3 percent or more. At the same time, Congress passed a 20 percent rise in benefits for current Social Security recipients. As of July 1980, over 90 percent of the elderly were receiving Social Security payments. The average monthly benefit was $330 for a retired worker, $538 for a retired couple, and $305 for an elderly widow or widower.

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4. A person's countable monthly income in 1981 excluded the first $20 of any unearned income (for example, Social Security benefits), the first $65 of any earned income, plus half of any earnings over $65. Resources needed to be under $1,500 for any single person, but excluded the value of a home, a car valued at under $4,500, and life insurance with a face value of $1,500 or less, plus reasonable household and personal possessions.

5. U.S. Department of Health and Human Services, Social Security Administration, *Social Security Bulletin, Annual Statistical Supplement, 1981* (Washington, D.C.: U.S. Government Printing Office, 1981), tables 154 and 156.

Benefits for 1980 were 140 percent more than 1970 levels, an increase that outstripped price increases, which rose 106 percent over the decade.

The 1975 Amendment to the Social Security Act

Social Services, Title XX. With the passage of Title XX, states were given increased authority, responsibility, and flexibility in choosing and running social services programs for neglected, abused, and dependent children and adults. Under the legislation, beneficiaries of Title XX services could be AFDC, SSI, or Medicaid recipients, but could also be residents earning up to 115 percent of the state median income. This condition allowed states to provide in-home services for elderly persons who were not covered under Medicaid. The services prevented or delayed nursing home placement for many elderly unable to live independently without some external support.

The Effects of Federal Programs by 1981

By the mid-1970s, the legislation had authorized a set of programs designed to meet the income and health needs of most elderly. What impact did this legislation have on the low-income elderly by the end of the Carter administration? This is a difficult question to answer. We begin by noting that the policy expansion of the 1960s and 1970s did not produce any legislation directed exclusively toward the low-income elderly. Social Security and Medicare—programs from which large numbers of low-income elderly undoubtedly benefit—*are age-entitlement programs*, as are those provided under the Older Americans Act. These programs benefit all elderly, regardless of their other sources or their level of income. SSI and Medicaid are *means-tested programs* for which the elderly must qualify as must other low-income groups, by demonstrating that their income falls below the eligibility threshold.

Changes Introduced by Amendments to the Social Security Act

The major strides toward improving the economic status of the elderly have come through changes in and expansion of Social Security benefits. The 1972 amendments increased the average benefit level and tied future benefit increases to inflation. The two years from 1979 to 1981 alone saw federal outlays for Social Security rise from $69 billion to $97 billion, largely as a result of increases in monthly benefits. (Average monthly benefits for retired workers rose from $294 to $386 over this two-year period.)

As noted earlier, the improvements in Social Security have brought many elderly out of poverty, but they have done relatively little to ameliorate conditions for those who had tenuous or unprofitable attachments to the labor force during their preretirement years. Congress has been reluctant to increase minimum benefits for these people. The minimum benefit approach to reducing poverty among the elderly has, as Lammers notes, a serious flaw:

> To increase the income of those who qualify for Social Security benefits and have no other income, substantial sums are spent on individuals who have qualified for the minimum under Social Security but actually use this income to supplement other pensions and income sources. In 1977 Congress moved to create a special minimum benefit based on the needs of those who had worked for a longer period of time at low wages. . . . The use of special minimum benefits did not develop sufficiently to alleviate the basic problem, however, so that by 1981 the pattern of minimum benefit allocations going to those with substantial alternative revenue sources remained.[6]

In 1981, 87 percent of the elderly living below the poverty threshold were receiving some Social Security benefits. One-third of this population was living on Social Security benefits alone. With average monthly payments to retired workers placing recipients just above the poverty line, it is clear that those receiving minimum or reduced benefits needed additional financial assistance to avoid serious economic hardships.

As can be seen in table 24, persons receiving only the minimum Social Security benefit in 1981 would have incomes 53 percent below the poverty threshold for that year. This is an improvement of only 6 percent over 1970 levels. Average monthly benefits have, in contrast, increased substantially relative to the poverty threshold. In 1970 the average individual payment was 24 percent below the poverty level. By 1981 the average payment was slightly above the threshold. Similarly, a retired worker and spouse receiving average monthly Social Security payments that placed them at the poverty level in 1970 were 34 percent above the threshold in 1981. The data in the table make clear the fact that Social Security increases have benefited many elderly, but not all.

Supplemental Security Income was originally designed for both those ineligible for Social Security and those receiving low Social Security benefits. This program was to be the answer to the dilemma of trying to provide a guaranteed minimum for the low-income elderly (and other categorically eligible populations) while not benefiting those with other significant income sources. However, the program has not grown as expected for the elderly population. Between 1975 and 1981, for example, increases in Social Security

6. Lammers, "Public Policy," p. 112.

TABLE 24

MONTHLY AVERAGE SOCIAL SECURITY BENEFITS FOR THE ELDERLY AND THEIR FAMILIES, COMPARED TO POVERTY THRESHOLD, 1970 AND 1981
(Dollars per month unless otherwise indicated)

	Persons Aged 65 or Older (Workers and Widows or Widowers)		*Families Headed by Recipient Aged 65 or Older*	
Measure	*1970*	*1981*	*1970*	*1981*
Poverty-level income	155.08	363.33	195.67	458.33[a]
Minimum Social Security benefits	64.00	170.30	96.00	255.50[b]
Percent of poverty-level income	41.3	46.9	49.1	55.7
Average Social Security benefits	118.10	385.97	198.90	488.60[c]
Percentage of poverty-level income	76.2	106.2	101.7	133.7

SOURCE: U.S. Department of Health and Human Services, Social Security Administration, *Social Security Bulletin, Annual Statistical Supplement, 1981*, (Washington, D.C.: Government Printing Office, 1982), table 6 (monthly poverty level), table 32 (minimum monthly benefits), table 16 (individual average monthly benefits), and table 47 (family average monthly benefits).

a. Poverty level for a two-person family with head of household age sixty-five or older.

b. Family benefit given for any family structure—worker and spouse; worker, spouse, and child; widow or widower (age sixty-five or older) and one or more children.

c. Average monthly payment to worker and spouse; a widow and child receive $532.90. Data (and percentage of poverty) are for 1979.

benefits and beneficiaries far outstripped those in SSI. Average Social Security benefits increased 19 percent in inflation-adjusted terms while average SSI benefits for the elderly dropped 4 percent in real terms. The number of elderly SSI recipients qualifying first as "aged" dropped 22 percent while the number of Social Security recipients increased by an almost equal amount. One could argue that the decline in the number of elderly receiving SSI is in line with the increases in Social Security benefits were it not for the fact that 87 percent of the elderly living below the poverty threshold in 1981 were Social Security recipients.

SSI, like Social Security, is means-tested and is indexed to inflation. However, the federal SSI income floor (the guaranteed minimum income and therefore the maximum income a person can earn, after adjustments, without becoming ineligible for SSI) is about 27 percent below the poverty level.

This gap between the programs means that with each cost-of-living increase some Social Security recipients become ineligible for SSI payments (it was estimated that with the 1975 cost-of-living adjustment, 66,241 elderly became ineligible for SSI benefits).[7]

More important, the low eligibility cutoffs for SSI mean that a significant number of elderly receive Social Security benefits that are too high to allow them to collect SSI but too low to allow them to provide for themselves adequately. In 1981 only 26 percent of the elderly below poverty (about 1 million persons) were receiving SSI payments. It was originally estimated that about one-fifth of all elderly Social Security recipients, 4.6 million people in 1981, would receive both SSI and Social Security benefits once the SSI program became fully operational.[8] The total number of SSI recipients in 1981 was 1.7 million, less than half of the predicted number.[9] State supplements to the federal payments lifted about 700,000 of these recipients above the official poverty line.

The low federal SSI income limit means more than a loss of needed supplementary income to many elderly Americans; it means a possible loss of medical coverage through Medicaid when they lose their categorical eligibility as SSI recipients. Losing Medicaid eligibility also entails a loss of resources to pay the recipient's share of Medicare. Medicare deductibles and copayments rose 122 percent between 1975 and 1981, while average Social Security benefits for an individual retired worker rose only 86 percent (minimum benefits rose only 72 percent). These increases mean that elderly persons requiring hospitalization in 1981 paid a minimum of $336 in deductibles and premiums—7 percent of the average Social Security recipient's total annual benefits and 18 percent of the total annual benefits of the elderly person receiving minimum payments. If these elderly were eligible, Medicaid picked up the hospital charges. However, the elderly who require prescription drugs, in-home care, or long-term nursing home care, who are not SSI recipients, and who are not able to afford private supplementary coverage face serious financial trouble.

States can provide Medicaid coverage, at their option, to residents deemed medically needy. The fact that 33 percent of the below-poverty elderly received Medicaid coverage in 1981 while only 26 percent were SSI recipients

7. U.S. Department of Health, Education, and Welfare, SSI Study Group, *Report to the Commissioner of Social Security and the Secretary of Health, Education, and Welfare on the Supplemental Security Income Program* (n.p.: January 1976), p. 71.

8. Joseph A. Pechman, ed., *Setting National Priorities: The 1974 Budget* (Washington, D.C.: Brookings Institution, 1983), p. 113.

9. U.S. Census, *Current Population Reports*, series P-60, no. 138 (1981), table 15.

suggests that states use this option. Nonetheless, it is an option and not a requirement. States facing tight fiscal times may curtail their program for the medically needy under Medicaid.

Changes in Nutrition, Housing, and Other Noncash Benefits

Although the SSI program has not been as effective as envisioned in removing more elderly from poverty status, other programs do supplement the income of the low-income elderly. In 1981 almost 1 million elderly lived in federally assisted housing, and more than 1 million received food stamps. These supplementary programs are also means-tested—to be eligible for them an applicant must not have income above the levels specified by the program. As shown in table 25, not all these recipients were below the official poverty level, although all met the income requirements of the programs from which they benefited. For example, while only half of the elderly households living in publicly owned or subsidized rental housing were officially below poverty, 83 percent had incomes below $7,500. Those with incomes slightly above the poverty threshold receive a proportionately smaller subsidy.

In addition to the means-tested programs shown in table 25, other programs serve the low-income elderly. Most notable of these are congregate and home-delivered meals, the nutrition programs offered under the Older Americans Act. These programs served about 3 million elderly in 1981. Federal mass transit assistance also helps the low-income elderly because it

TABLE 25

ELDERLY HOUSEHOLDS RECEIVING MEANS-TESTED BENEFITS, SELECTED PROGRAMS, 1981

	All Elderly Households (N = 17.3 Million)		*Below-Poverty Elderly Households (N = 3.2 Million)*	
Benefit Received	*Number (thousands)*	*Percent*	*Number (thousands)*	*Percent*
Food stamps	1,143	6.6	815	25.5
Medicaid	2,505	14.5	1,134	35.3
Subsidized housing	949	5.5	433	13.5
Supplemental Security Income	1,499	8.7	894	27.9
All benefits	104	0.6	97	3.0
No benefits	13,698	79.1	1,561	49.0

SOURCE: Derived from data in U.S. Bureau of the Census, *Current Population Reports*, series P-60, no. 136 (Washington, D.C.: U.S. Government Printing Office, 1983), table 10.

enables cities to keep public transportation costs down for all residents and to provide reduced-fare transportation to the elderly and handicapped.

It is difficult to assess the cumulative influence of multiple benefits (for example, Social Security, SSI, Medicaid, Medicare, and food stamps) on the incidence of poverty in the elderly population simply because of the complexities involved in tracking recipients through multiple programs. A Congressional Budget Office report issued in 1977 estimated that the number of elderly living below the poverty threshold would have been almost ten times its 1977 level had the elderly not been able to benefit from the various social insurance (such as Social Security), money transfer (SSI, for instance), and in-kind transfer (like Medicaid and food stamps) programs now in existence.[10] The effect of the non-health-related, in-kind transfer programs (housing subsidies and food stamps) is small compared to the other programs. Even so, these general means-tested programs reduced the poverty rolls an estimated 15.5 percent in 1977. Medicaid, Medicare, food stamps, housing assistance, and SSI—the major programs that extend the income security provided to most elderly through Social Security—reduced the number of elderly living in poverty by 72 percent, a significant reduction by any reckoning. Yet in 1981 half the elderly living below the poverty threshold were not receiving SSI, food stamps, Medicaid, or housing assistance, as can be seen in the last row of table 26. By 1981 the array of federal programs that were developed during the 1960s and 1970s had certainly increased the financial security of

TABLE 26

GROWTH OF FEDERAL BENEFITS FOR THE ELDERLY BY PROGRAM, SELECTED PERIODS, 1979–83

Program	*1979 Total Outlays ($ Billions)*	*Percent Change*	
		1979–81	*1981–83*
Food stamps	0.5	80.0	−22.2
Medicaid	4.3	39.5	11.7
Medicare	24.6	52.9	19.2
Social Security	69.0	48.9	25.3
Subsidized public housing	1.6	43.8	60.9
Supplemental Security Income	1.7	40.7	25.8

SOURCE: U.S. Bureau of the Census, *Statistical Abstract of the United States: 1984* (Washington, D.C.: U.S. Government Printing Office, 1983), table 616.

10. Congressional Budget Office, *Poverty Status of Families under Alternative Definitions of Income*, unpublished background paper 17 (Washington, D.C.: CBO, 1977).

the low-income elderly, but these programs did not guarantee an existence above the poverty level for many elderly households.

Federal Legislation and Policy Changes Affecting the Low-Income Elderly, 1981–84

The Reagan administration's initial position on assisting the elderly has been described as follows:

> The Reagan administration came to Washington in 1981 placing a high priority on its economic policy agenda and a plan to shrink the federal government's role in most domestic areas. While it hoped that economic growth would benefit everyone, and a pledge was made to preserve the "social safety net," it did not have a social agenda that addressed specifically those issues of particular concern to the elderly. Thus, there have been no initiatives by the administration to increase the incomes of the needy aged through transfer payments, improve directly medical or institution care, protect the elderly against crime, improve employment opportunities for older workers, or construct more housing for the elderly.[11]

The administration did, however, have a general approach to assisting the elderly population in meeting its financial needs that went along with its broad economic policies. Reasoning that inflation was the principal drain on households with fixed incomes, the administration maintained that its policies designed to reduce inflation and promote economic growth were the best social insurance the government could provide. Furthermore, since elderly voters make up an important part of the electorate, programs benefiting them have not been the target of major retrenchment efforts.

In fact, at every income level the elderly experienced income growth under the current administration, suggesting that they have benefited in some respects from administration policies and the economic conditions prevailing between 1980 and 1984. Thus one study found "Over the 1980-1984 period, the disposable incomes of families headed by someone sixty-five or older rose by 9.5 percent—nearly three times the increase . . . for all families. Older individuals living alone had even greater gains—their incomes rose about 15 percent. . . . Even the bottom quintile enjoyed income increases of about 6 percent."[12]

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11. James Storey, *Older Americans in the Reagan Era: Impacts of Federal Policy Changes* (Washington, D.C: Urban Institute Press, 1983), p. 22.

12. Marilyn Moon and Isabel V. Sawhill, "Family Incomes," in John L. Palmer and Isabel V. Sawhill, eds., *The Reagan Record: An Assessment of America's Changing Domestic Priorities* (Cambridge, Massachusetts: Ballinger, 1984), pp. 317–46.

Elderly households benefited during the early 1980s from low inflation and high interest rates and were not appreciably affected by the high unemployment experienced by the nation as a whole.[13] Although Social Security outlays slowed during these years, as shown in table 26, lower inflation (and hence lower cost-of-living adjustments) accounts for these changes; real Social Security benefits rose 7 percent during the period.[14]

Table 26 also shows that growth in federal outlays for the other major programs serving the elderly was generally slower between 1981 and 1983 than between 1979 and 1981. In only one program, food stamps, was there an actual reduction in funding from 1981 to 1983. To the extent that the low-income elderly have been affected by budget cuts and policy changes, they have been hurt because of the cumulative buildup of small reductions in benefits and services. These losses are difficult to document and are best identified at the local level (see chapter 9). The legislative changes made by the Reagan administration are outlined below.

Social Security and SSI

The major change in Social Security outlays under the Reagan administration was a six-month delay in the cost-of-living increase. Under the new law, these increases are paid in January instead of the preceding July. The delay, enacted in the Social Security Amendments of 1983, is projected to save about $9.7 billion in Social Security outlays between 1983 and 1985. Most significant are the administration's proposals for changes in Social Security that were not enacted. Reagan had proposed eliminating the minimum benefit for all current recipients, but Congress rejected this proposal. The minimum benefit was eliminated only for new beneficiaries under the 1981 Omnibus Budget Reconciliation Act.

Built into the 1983 legislation was income protection for low-income beneficiaries who receive SSI: these persons were given benefit increases (up to $20 monthly for single persons and $30 monthly for married couples) to offset the six-month delay in cost-of-living increases. The 1983 legislation may work to decrease the percentage of elderly who are below the poverty line and receive SSI—it requires the Social Security Administration to notify certain Social Security recipients of their possible eligibility for SSI.

It remains to be seen whether future retirees will be able to utilize SSI to compensate for the loss of Social Security minimum benefit payments: "There appear to have been approximately 2 million persons among the 3.1

13. Ibid.
14. Ibid.

million individuals receiving the minimum benefit who would not be eligible for SSI either because their incomes were too high (from other sources such as government pensions), or they were between the age of sixty-two and sixty-five."[15]

Some of these persons are the "double-dippers" at whom the legislative change was aimed. Others, however, may find themselves joining the ranks of the low-income elderly who are caught in the gap between the two income security programs.

As discussed in chapter 5, the Reagan administration did not make any major legislative changes in the SSI program except, as mentioned above, the increase to offset the delay in the cost-of-living allowance. The main administrative change—tightened eligibility requirements and more frequent case reviews—did not affect the elderly, whose age-based claims to SSI are indisputable.

Food Stamps

Benefits from the food stamp program, redeemable food coupons to low-income families and individuals, are federally funded and do not vary by state. These benefits are based on the "Thrifty Food Plan" index, which was developed by the Department of Agriculture. Benefits received equal 100 percent of the Thrifty Food Plan amount appropriate for the household size, minus thirty cents for each dollar of countable income. Under the Omnibus Budget Reconciliation Act of 1981 the inflation adjustment for 1982 benefits was eliminated and certain later inflation adjustments were postponed. First-month benefits were prorated based on date of application, and households with gross monthly incomes of over 130 percent of the official federal poverty index were declared ineligible *unless they had elderly or disabled members*.

The elderly thus escaped the income-related cuts in 1981 but were affected by further across-the-board reductions enacted in 1982. The basic benefit amount was reduced from 100 percent to 99 percent of the Thrifty Food Plan amount for fiscal years 1983 to 1982 and benefits were rounded down to the next lowest dollar.

Housing Assistance

Housing assistance is provided to low-income families through three major programs—public housing, federally subsidized, newly constructed or rehabilitated units built by the private sector (Section 8 and Section 202

15. Lammers, "Public Policy," p. 112–13.

housing), and direct rent subsidies to individuals and families living in existing private market housing. In 1980 about 3.1 million households were being served under these programs, 40 percent of which were headed by elderly persons. The Section 202 housing construction program in that year included the highest percentage of elderly (about 80 percent), because this program provides direct federal construction loans for the development of housing projects to serve elderly and handicapped individuals.

The system of housing programs grew in both budgetary commitments and the number of households assisted until the advent of the Reagan administration.[16] Since then the policy for housing assistance has essentially been to reduce spending by eliminating funding for additional subsidized units and by decisively moving away from new construction and rehabilitation toward more cost-efficient rental subsidies.

In 1981 Congress moved to ensure an even mix of existing, new, and rehabilitated housing, reversing a pattern of HUD-promoted reductions in the role of subsidies for existing housing. The current administration, however, has moved far beyond this adjustment to an almost sole reliance on existing housing. Total new commitments for public housing and Section 8 housing fell from 206,000 units in 1980 to 100,000 units for 1984. The Congressional Budget Office reports total housing assistance outlays were reduced by $1.8 billion for 1982-85 compared to previous policy, largely due to reduced new commitments.[17] Because housing commitments are long-term, the effects of the decreased outlays will continue far into the future. Reductions in units subsidized by the U.S. Department of Housing and Urban Development would have been greater if Congress had passed the additional recisions proposed by President Reagan in 1983.

In addition to reducing the number of subsidized units available, the administration changed the eligibility requirements and the expected contribution of those placed in subsidized units. The maximum percentage of occupants of HUD-subsidized housing with incomes between 50 and 80 percent of the median income (that is, the near poor) was lowered from 20 percent to 10 percent. In addition to this change, the required rent in subsidized units will rise from 25 to 30 percent of countable income between 1982 and 1986. It has been estimated that this new requirement will reduce the eligible pool of elderly households by one-third.[18] Of those elderly households actually

16. James P. Zais, Raymond J. Struyk, and Thomas G. Thibodeau, *Housing Assistance for Older Americans: The Reagan Prescription* (Washington, D.C.: Urban Institute Press, 1982).

17. Congressional Budget Office, "Major Legislation Changes in Human Resources Programs Since January 1981," staff memorandum, August 1983.

18. Zais, Struyk, and Thibodeau, *Housing Assistance*.

residing in assisted housing, about one-fifth will be ineligible under the new rule. The provision increasing rents to 30 percent of countable income will make one in nine participating elderly households ineligible. All changes combined eliminate eligibility for about one-fourth of participating elderly households.

Health Care

Medicare. The major change made in Medicare in 1981 was an increase in deductibles for hospital payments and medical costs. In 1980 the deductible for Medicare hospital insurance stood at $180. It rose to $204 in 1981, to $260 in 1982 and to $304 in 1983—a 69 percent increase in a three-year period. In addition, copayments for daily hospital costs for the sixty-first through the ninetieth day of hospitalization increased over the same period from $45 to $76 per day; for the ninety-first and subsequent days from $90 to $152 per day; and for the twenty-first and subsequent days of skilled nursing facility care from $22.50 to $38.00 per day. All of these are 69 percent increases between 1980 and 1983.

In 1982 Congress raised the premiums that the elderly must pay for supplementary medical insurance. These premiums rose from $9.60 in 1980 to $12.20 in 1983, for a 27 percent increase in three years. In addition, deductibles went from $60, which they had been since 1973, to $75—a 25 percent increase, but a reasonable one in light of inflation during that ten-year period. Medicare beneficiaries must also pay their own physicians if their doctors' fees exceed the maximum allowable under Medicare. Only about half of all nonhospital physician visits are fully reimbursed by Medicare. In chapter 9 we explore the meaning of these federal program changes for elderly persons at the local level.

Congress also acted in 1982 to limit the level of Medicare reimbursement to hospitals, and in 1983 established payment mechanisms based on the average cost to treat a condition with a particular diagnosis rather than reimbursing for actual costs. It remains to be seen whether hospitals respond to these constraints by lowering their actual costs or by adopting cost-cutting—and potentially harmful—practices such as reducing the quality of care, discharging patients who have no appropriate place to go, or avoiding expensive but necessary treatments.

Medicaid. Congress also acted in 1981 to lower the federal share of Medicaid costs. Federal matching contributions were reduced by 3.0 percent in 1982, 4.0 percent in 1983, and 4.5 percent in 1984. In exchange for this reduced support, states were given more freedom to shape their own Medicaid programs. New approaches to population and service coverage and new reim-

bursement mechanisms were permitted, and new delivery methods were encouraged. States have used this increased latitude to revamp their programs, that is, increase their efficiency. There have been service cutbacks, however, particularly in the optional services (for example, dental care, podiatry, optometry, prescription drugs) that states were required to provide as a condition of participation in the program. These services appear to be particularly relevant to older people. Loss of Medicaid coverage frequently means that the poor elderly go without these sources.

Social Services

Because of its flexibility, the social services block grant, formerly Title XX, is used to provide a variety of in-home, supportive, and protective services to the elderly. Funding for these services also bore serious cutbacks under the current administration. Grants funded under the Older Americans Act to Area Agencies on Aging for nutritional and other supportive services also lost funding under President Reagan. Congress appropriated $673 million in fiscal 1981; funding dropped to $636 million in fiscal 1982 but by fiscal 1984 it had been restored at its fiscal 1981 level—a loss of 14 percent in program dollars when adjusted for inflation.

Summary

During the 1960s and 1970s several administrations, both Republican and Democratic, contributed to the development of a network of social programs benefiting the elderly. These programs dramatically reduced the proportion of the elderly population living in poverty. More than 90 percent of the elderly receive Social Security, and their income from this source has more than kept pace with inflation since mid-1975 when benefits were indexed to the consumer price index. Medicare and Medicaid provide significant amounts of medical care, and other programs supply an array of noncash benefits including food, housing, and social services.

The major federal programs benefiting the elderly do not differentiate among elderly households on the basis of their financial or human resources. As the data in chapter 7 indicate, the elderly have quite heterogeneous characteristics, and many are fully able to support themselves without government assistance. Even before Reagan assumed the presidency, many critics believed programs serving the elderly needed restructuring to target most public resources on that small segment of older Americans in greatest need.

When the Reagan administration took office in 1981, it made no promises to protect the elderly beyond its general pledge to preserve the "social safety

net," its commitment to maintain Social Security, and its philosophy that economic policies to reduce inflation were the best way to assure the well-being of elderly citizens. Low inflation and high interest rates have indeed benefited elderly households at all income levels, with real disposable income rising an average of 9.5 percent between 1980 and 1984. But no restructuring has occurred that focuses on more precise targeting of resources away from the well-off and toward the needy.

The numerous changes in income security, health, housing, and social services programs that the administration pushed through Congress did not specifically protect or exempt elderly recipients from cuts, with the exception of the 1981 food stamps legislation. As a small but highly vulnerable subset of older Americans, the low-income elderly have undoubtedly been affected, although the extent of the impact is difficult to assess. Each change or cutback has not been dramatic, but the cumulative effects may be large for the elderly who rely on multiple public benefits with few or no other sources of income. The 1981 cuts in food stamps and housing subsidies alone were estimated at $19 a month for an elderly couple receiving SSI payments and $13 a month for an unmarried person.[19] These sums represent 3.0 and 3.4 percent, respectively, of average monthly federal payments for Social Security or Social Security and SSI combined. For someone receiving only SSI, they represent 10-11 percent of their average federal cash payments.

In other words, the loss of these noncash benefits means that poor elderly persons must compensate with their available cash to make ends meet at the rate of 3-10 percent of their average monthly income from federal sources.[20] Most have no other source of income, so these changes can easily push strained budgets to the limit. In combination with increased deductibles and copayments for health insurance and health care, the poor elderly often face impossible choices among food, shelter, utilities, and health care. Against the backdrop of improved circumstances for most elderly households, such outcomes seem particularly incongruous.

The effects of these federal changes can only be guessed. In chapter 9, therefore, we move to the local level and to the impressions of service providers and advocates. Where federal programs have local administrative counterparts with budgetary discretion (the social services block grant that replaced Title XX and Area Agencies on Aging), we look at those local programs and

19. Estimated by the Congressional Budget Office in a report to Senator Edward Kennedy, September 28, 1981.

20. U.S. Department of Health and Human Services, Social Security Administration, *Social Security Bulletin: Annual Statistical Supplement, 1982* (Washington, D.C.: Government Printing Office, 1983), pp. I-II and Tables 167, 170, and 185.

budgets. For most of the programs described in this chapter, however, local offices simply administer federal eligibility and program requirements with little or no local discretion (food stamps, Medicare, Medicaid, and housing assistance). Local providers and advocates have much to say about how federal changes in these programs have affected their patients or members. These impressions are combined with the data from local social services departments and Area Agencies on Aging in chapter 9; we do not repeat the basic data on federal changes there.

CHAPTER 9

WHAT HAS HAPPENED TO THE LOW-INCOME ELDERLY?

Local providers and advocates in the four cities investigated have much to say about the effects that changes in Social Security, SSI, food stamps, Medicare, and Medicaid programs have had on the low-income elderly in their jurisdictions. The federalized structure of these programs, however, has meant that the local offices administering them have little or no discretion in selecting eligible participants, deciding what types of payment these participants can receive, or determining what types of services the local staff can provide. Where local providers can give insights into how their low-income elderly have been affected by changes in Social Security, SSI, Medicare, Medicaid, food stamp and housing subsidy changes, we incorporate these comments in the discussion of local impact.

The focus of this chapter is on services funded through the social service block grant and the Older Americans Act. Although these funding sources account for a small part of the overall federal investment in the economic well-being of older Americans, they represent the major federal support for *direct services* to this population, and therefore the source of funding for programs that help the low-income elderly maintain their independence. They are also the programs over which local governments have the most control.

State Funding Patterns

Title XX (after 1982, the social services block grant) support was used to pay for a variety of services to low-income elderly people. The biggest service component for the elderly funded through this source was in-home services (chore, homemaker, personal care) to prevent or delay placement of the elderly in nursing homes. These services were frequently coordinated with home health services supported by Medicaid and Medicare. Other services

receiving Title XX-social services block grant funding included case management, adult day care, and other miscellaneous services.

Funding provided by the Older Americans Act supported congregate and home-delivered meals (its biggest program), social services, some day care and transportation, community and legal services, and employment. Older Americans Act funding has remained relatively stable during the early 1980s at the federal level, experiencing slight increases in some service areas and substantial reductions in only one—senior employment. Thus state or local replacement of lost federal revenues is not an issue for Older Americans Act funding as it is for Title XX.

Table 27 shows the drop in Title XX-social services block-grant funding between fiscal years 1981 and 1983 in the states of the four cities we investigated and how these states adjusted to decreases in federal support. California and Massachusetts replaced more than the total amount of money lost from Title XX in the transition to the social services block grant. In Massachusetts, replacement and overreplacement used entirely state funds. In California, two-thirds of the change in nonblock spending came from the state budget, and one-third came from local government resources. Michigan was not able to replace 100 percent of lost Title XX revenues, but did replace 82 percent. Michigan's reassignment of social services block grant dollars caused a $12.7 million loss of other federal support for the same services, in addition to the funding cut from the Title XX-social services block-grant transition. Local and state resources compensated for both the social services block-grant cuts and the other federal losses, with local resources providing nearly four-fifths of the increase in nonblock spending. Of the four states, only Virginia did not replace lost Title XX revenues. In fact, state and local support for services previously funded through this source dropped slightly in Virginia.

City and County Funding Patterns

Title XX-Social Services Block Grant

State data on Title XX-social services block grant changes are interesting but do not give a very accurate picture of what happened to adult services at the local level in the four jurisdictions we studied. Table 28 presents sources of funding for adult social services in the four cities for fiscal years 1981 to 1983. The table shows that all cities experienced a drop in Title XX-social services block grant funding for adult services during this period, although the magnitude of that drop is quite different from the drop at the state level in all funding from this source. This occurred because the states shifted their funding patterns, often reducing the amount of block grant resources used for

TABLE 27

CHANGES IN SOCIAL SERVICES BLOCK GRANT FUNDS AND REPLACEMENT OF FEDERAL DOLLARS, FISCAL YEARS 1981–83[a]
(Millions of Dollars unless Otherwise Indicated)

Item	*California*	*Massa-chusetts*	*Michigan*	*Virginia*
Title XX–social services block grant				
Funding, fiscal 1981 (Title XX, federal)	304.6	78.7	115.6	64.8
Total funding for social services[b]	732.3	134.8	580.4	85.4
Funding, fiscal 1983 (block grant)	257.4	61.7	108.0	57.3
Total funding for social services[b]	753.9	147.6	579.0	76.0
Percent change, 1981–83				
Block grant	−15.5	−21.6	−6.6	−11.5
Total	2.9	9.1	−0.2	−11.0
Percent nominal replacement of reduced block grant funds[c]	145.8	174.0	81.6	−25.3
Change in nonblock spending				
Total change	68.8	29.6	6.1	−1.9
Other federal change	20.7	−0.3	−12.7	0.0
State change	47.0	29.9	4.0	−0.3
Local change	1.2	0.0	14.8	−1.6

SOURCE: Eugene C. Durman, Barbara A. Davis, and Randall R. Bovbjerg, "Block Grants and the New Federalism: The Second Year Experience," Research Paper 3076-01 (Washington, D.C.: The Urban Institute, April 1984), tables 1 and 2.

a. Results between 0 and 100 reflect partial replacement. Numbers over 100 indicate states that have increased total spending by more than the loss of federal dollars. Negative numbers show instances in which total funding was reduced by more than the loss of federal block grant dollars. This table presents changes in nominal terms. If inflation of about 7 percent per year (the average inflation in state and local purchase of goods and services) is added, the magnitude of replacement would be less.

b. Total includes state, local, and other federal funds in addition to block grant or Title XX dollars.

c. The extent of replacement was measured as loss of federal block grant dollars minus loss of total social service dollars, all divided by loss of federal block grant dollars.

adult services and in one instance (Richmond) reducing the city's share of state funds. In some instances these shifts away from adult services were

TABLE 28

LOCAL CHANGES IN TITLE XX–SOCIAL SERVICES BLOCK GRANT AND OTHER FUNDING FOR ADULT SOCIAL SERVICES, FISCAL YEARS 1981–83

City and Type of Funding	Budget ($ Thousands)			Percent Change, 1981–83	
	1981	1982	1983	Current Dollars	Constant Dollars
San Diego					
Title XX–block grant[a]	n.a.	3,893	3,824	−2	−6
Refugee Resettlement[a]	n.a.	869	74	−91	−92
State[a,b]	n.a.	938	1,079	15	10
County	2,396	2,365	1,478	−38	−44
Total	7,711	7,355	6,455	−16	−24
Detroit[c]					
Title XX–block grant	44,536	31,576	31,371	−30	−36
Other	57,825	91,159	91,416	58	43
Total	102,361	122,735	122,787	20	8
Richmond					
Title XX–block grant	8,200	8,089	6,132	−25	−32
State	590	526	404	−31	−38
City	2,360	2,106	1,618	−31	−38
Total	11,150	10,721	8,154	−27	−34
Boston					
Title XX–block grant	4,746	0	0	−100	−100
State	8,875	15,181	16,118	82	64
Total	13,621	15,181	16,118	18	7

SOURCES: Local social services budget documents. Figures are rounded.

n.a. Not available.

a. Reflects 1982–83 change.

b. Does not include $9.4 million in each year of state-administered payments to individual providers for in-home social services.

c. Data are for Michigan as a whole. Detroit (Wayne County) accounts for approximately half of adult services expenditures in that state. "Other" includes both state and local resources, with local funding accounting for approximately 80 percent. See table 27.

compensated by state or local replacement, but in other instances they were not.

San Diego lost little of its Title XX funding with the shift to the social services block grant, and state replacement more than compensated for that drop. However, San Diego's county funding dropped almost 50 percent in real terms during the same period, reflecting county priorities for programs besides adult services. Overall San Diego's adult services program lost 24

percent of its funding between 1981 and 1983 (in constant dollars, after adjusting for inflation), and has had to cut services accordingly.

Detroit lost approximately one-third of its Title XX funding for adult services with the shift to the block grant and local resources more than compensated for the loss. Massachusetts had been funding an increasing proportion of its adult services with state money, greatly exceeding the required 25 percent match for Title XX. With the advent of the social services block grant, Massachusetts decided to switch all its federal funding into children's services and to pick up in-home services for its elderly citizens with state funding. As in Detroit, funding for these services in Boston and in all of Massachusetts increased during the years under study because of the state's commitment to support them.

Richmond is the only one among the four cities in which adult services lost heavily from Title XX-social services block grant cuts and in which little occurred to compensate for the loss. Adult services cuts in Richmond during the first post-Reagan year due to the block grant cuts, but the cuts between fiscal years 1982 and 1983 occurred because the state changed its social services block grant allocation formula in a way that seriously hurt Richmond. These cuts followed others between fiscal 1980 and fiscal 1981 due to local circumstances, but the cumulative impact has been devastating. Adult services lost twenty-three positions from 1980 to 1983 and its purchase-of-services budget dropped 91 percent, from $1.4 million in fiscal 1980 to $0.1 million in fiscal 1983. Purchased services included in-home supportive services, adult day care, legal services, and adult protective services.

Area Agencies on Aging

Turning to the budgets for Area Agencies on Aging in the four cities, (table 29), we see that these agencies in three out of four cities lost ground in constant dollar terms between 1981 and 1983, despite relatively unchanged federal funding levels. In all four cities the agencies experienced inflation-adjusted losses in federal financial support. Local funding decreased in all four cities, but San Diego and Detroit had state funding increases to compensate for local cuts. This was not the case in Boston or Richmond.

Caseloads

Budget data do not tell the whole story, but must be matched with caseload figures to understand the actual pressures on local agency resources. Table 30 shows available caseload information in the four cities.

TABLE 29

BUDGETS FOR AREA AGENCIES ON AGING IN SAN DIEGO, DETROIT, RICHMOND, AND BOSTON, STATE FISCAL YEARS 1981–83

City and Funding Source	Budget ($ Thousands)			Percent Change, 1981–83	
	1981	1982	1983	Current Dollars	Constant Dollars
San Diego					
Older Americans Act	4,294	4,834	4,450	4	−6
Other federal	1,402	1,425	1,182	−16	−24
Total federal	5,696	6,259	5,632	−1	−11
State	479	818	1,450	203	174
County	663	365	378	−43	−48
Other	534	720	814	52	38
Total	7,372	8,162	8,274	12	1
Detroit[a]					
Older Americans Act	5,211	5,047	5,528	6	−4
Other federal	918	940	996	8	−2
Total federal	6,129	5,987	6,524	6	−4
State	702	1,043	1,039	48	34
City	76	76	26	−66	−69
Total	6,907	7,106	7,589	10	−1
Richmond[b]					
Older Americans Act	1,544	1,389	1,226	−21	−28
Other federal	109	105	356	227	195
Total federal	1,653	1,494	1,582	−4	−14
Boston[c]					
Older Americans Act	3,227	2,942	3,007	−7	−16
Other federal	54	332	415	669	595
Total federal	3,281	3,274	3,422	4	−6
State	0	15	90	*	*
City	2,065	1,791	1,901	−8	−17
Private grants and contributions	0	0	39	*	*
Total	5,346	5,080	5,452	2	−8

SOURCES: San Diego—Data derived from annual reports of the San Diego Area Agency on Aging; Detroit—Detroit Area Agency on Aging; Richmond—Richmond Area Agency on Aging; Boston—Boston Commission on Affairs of the Elderly. Figures are rounded.

* Lack of data precludes calculation.

a. In addition to the figures given, the budgets of the Detroit Area Agency on Aging for each year include approximately $350,000 in program income, generated largely by the nutrition programs.

b. State and local matching funds made up 14 percent of the total in 1981 and 1982 and 13 percent of the total in 1983. The agency did not construct its budget to show the state and local shares.

c. In addition to the figures given, each year's budget includes approximately $215,000 in administrative costs.

TABLE 30

CASELOAD CHANGES FOR LOW-INCOME ELDERLY, FISCAL YEARS 1981–83

City and Type of Service	*Number of Persons*			*Percent Change, 1981–83*
	1981	*1982*	*1983*	
San Diego				
In-home social services	6,940	6,518	6,400	−8
Adult protective services	1,469	1,300	1,000	−32
Services of Area Agency on Aging[a]				
Nutrition	11,021	13,853	13,511	23
Social services	22,686	43,752	27,306	20
Detroit				
In-home social services[b]	9,367	9,804	10,055	7
Adult protective services	647	620	760	17
Services of Area Agency on Aging[a]	n.a.	15,831	15,282[d]	−3[c]
Richmond				
In-home social services (per month)	210	30	30	−85
Adult protective services[e]	262	345	376	44
Services of Area Agency on Aging[a,f]	n.a.	185,881	203,698	10[d]
Boston				
Home-care	7,673	7,842	8,243	7
Services of Area Agency on Aging[a]	12,593	28,501	26,726	112

SOURCE: Agency records of the respective cities.

a. Counts are unduplicated *within* services, but duplicated *across* services.

b. In fiscal 1981, 6,081 persons were served through Title XX and 9,367 clients were served with either Title XX or Title XIX (Medicaid) funding. In fiscal years 1982 and 1983 all services were paid for by Title XIX.

c. Reflects change from 1982 to 1983.

d. This figure for fiscal 1983 is comparable to the fiscal 1982 figure because it includes counts of persons only for those services for which counts were also available in fiscal 1982. If we included persons receiving services for which no comparable 1982 counts were available—information and referral, congregate meals, nutrition education, transportation, legal services and advocacy—the figure would be 45,791.

e. Data represent complaints per year, which equal *new*, not ongoing cases.

f. Service units, not recipient counts.

Agencies can take one of two different approaches to dealing with budget changes—especially budget cuts. They can either cut the number of persons they serve but maintain the level of services for any individual recipient or

they can try to handle equal or greater numbers of persons but give them less intensive services. Comparing the budget data in table 29 with the caseload data in table 30 gives some insight into the ways the social service agencies in the four cities handled budget changes. Agencies handling adult social services in San Diego and Richmond took the former approach for in-home care, and San Diego did so also for adult protective services. These agencies lost staff because of budget cuts but elected to keep the workload approximately the same for the remaining staff, with the result that caseloads shrank for the agency as a whole.

Richmond's adult protective services staff was cut from ten to seven persons in fiscal 1983, and 100 ongoing cases were shifted to generic casework services. Yet the remaining staff still handled a caseload of complaints that represented a substantial increase over that served by the full staff complement the year before. Obviously workers had to reduce the amount of time they could devote to individual cases.

Detroit's social services agency experienced a postinflation growth of 8 percent and increased its caseload for in-home services by the same proportion. Boston also saw real growth in home care funding of 7 percent, and also passed it along in the form of increased caseload. In both San Diego and Richmond the changes and cuts beginning in 1981 followed equal or greater reductions in staff and services in previous years. There was no "fat" left in either agency after these earlier cuts, so the post-1981 changes had an especially severe impact.

The caseload data for Area Agencies on Aging, reported in table 30, are not as straightforward as those for social services agencies. The former deliver a greater range of services than the adult services units of social service agencies. Many of their services involve outreach, prevention, health check-ups, and other activities that reach large numbers of people for an hour or two apiece. Alternatively, people participate repeatedly in other services, especially congregate and home-delivered meals, transportation, friendly visits, and telephone reassurance. Area Agencies on Aging can shift resources among their progams and can greatly increase their service population by increasing their outreach and educational activities relative to their more intensive services.

When the caseload data for Area Agencies on Aging are compared with the budget data for the same cities, no clear pattern emerges between funding and service levels. Two of these agencies, in San Diego and Detroit, had virtually flat funding patterns (no more than a 1 percent increase or decrease in inflation-adjusted funding), yet one city shows a jump in recipient caseload of approximately 21 percent and the other city appears to have a decrease of approximately 3 percent in those services for which comparisons can be made.

Boston and Richmond both report real drops in funding of 8 percent and 14 percent, respectively, yet each reports increased caseloads. In Boston's case, the increase is over 100 percent. This increase results from nearly doubling the number of recipients who use some services and adding some services that were not offered in 1981. Before we turn to the effects of federal changes on service recipients and caseloads, we must first describe the structure of those services and the characteristics of the low-income elderly in the four cities.

Agency Service Structures and Populations Served[1]

In each location visited, two county agencies had primary responsibility for the low-income elderly and several more local agencies controlled some program or resource of great importance to this population. These service structures for the low-income elderly are by far more complicated than the structures for other populations included in this book. The two primary agencies assisting the low-income elderly were the social services department, division, or bureau, and the Area Agency on Aging. The picture is a complex one because both types of agencies purchase services by contract from a wide range of community-based organizations and individuals. In addition, adult services units must help their recipients negotiate the maze of federal health and income maintenance programs, even when these programs are administered by another division or bureau in the "umbrella" agency that also houses adult services.

San Diego

In San Diego the Department of Social Services' Adult Social Services unit provides in-home supportive services, adult protective services, and conservatorship services.[2] The casework performed by Adult Social Services staff is supplemented by in-home services purchased from many individual providers who supply homemaker, chore, and personal care services. A large proportion of the agency's recipients are poor and elderly.

The San Diego Area Agency on Aging supports programs through ninety or more purchase-of-service contracts for nutrition, in-home supportive ser-

1. Readers who are not concerned with the detailed service structures in the four jurisdictions might want to skip to the next section.

2. Adult protective services are defined broadly as assistance to adults who are neglected, exploited, or in circumstances that may endanger their health and safety. This assistance may include legal, housing, in-home support, mental health, case management, and other services. Conservatorship services involve establishing legal control over and managing a mentally incompetent person's financial affairs to promote that person's welfare.

vices, legal services, information and referral, transportation, and outreach. It also directly provides information and referral, an ombudsman program, and a multipurpose senior center that gives case management to the frail elderly. Contractors include five adult day health centers, several senior employment programs, three information and referral agencies, seven home care agencies, a legal services agency, twenty-five nutrition contractors operating forty-six sites, and several senior citizens centers.

Before the pressure from budget cuts, the Department of Social Services and the Area Agency on Aging both provided social and in-home supportive services for the elderly, but without any interagency coordination. Budgetary pressure has resulted in more coordination. Persons applying to the Area Agency on Aging for in-home services are now sent first to Adult Social Services to determine if they are income-eligible for services supported by the social services block grant. Services funded by the Area Agency on Aging are reserved for those "marginal" people who have incomes just above the block-grant maximum but who cannot afford to pay for the care they need.

Medicare and Medicaid (MediCal in California), food stamps, housing, transportation assistance, mental health, and other services relevant to the elderly are each administered by a different agency. Caseworkers can help elderly persons gain access to these services, but coordination sometimes fails.

In 1980, persons aged sixty-five and older comprised 9.7 percent of San Diego County's population. Of these 181,477 people, about 7 percent are below the poverty line, or 12,862 people. About 31 percent of the elderly live alone and have a higher incidence of poverty; about 14 percent of the unrelated persons aged sixty-five and older are below the poverty line. Looked at another way, 62 percent of the poor elderly in San Diego live alone. These figures have implications for the types of services they may need and the types of help they can or cannot expect from other family members.

The average caseload each month for in-home services to the elderly provided through the Department of Social Services is projected to be 6,400 for fiscal 1982. Since there were 65,589 household units in San Diego County containing elderly (persons aged sixty-five or older) by the 1980 census, and since in-home services can be thought of as serving households rather than individual persons, these services reach approximately 10 percent of all elderly households with services intended to prevent or delay placement in nursing homes. All these households meet the income requirements that were in effect under Title XX and are therefore low-income.

Of the 40,000 to 50,000 people served by the San Diego Area Agency on Aging each year, approximately 65 percent are people of "greatest eco-

nomic need," to use the agency's phrase. The agency does not record income levels for the elderly using its services, and the Older Americans Act explicitly rejects income as a basis for receiving services funded under the act.

Detroit

Public assistance and social services programs for Detroit residents, including those for the low-income elderly, are administered by the Michigan Department of Social Services through the Wayne County Area Office. Detroit constitutes approximately 50 percent of Wayne County's population but nearly 85 percent of its Department of Social Services recipients. As the designated Title XX-social services block grant agency, the department administers adult protective services, in-home services, and other case management and social services for adults. It manages the income maintenance and need-based assistance programs—Medicaid, Aid to Families with Dependent Children (AFDC), food stamps, the emergency needs program, and general assistance. It also operates a range of other services for AFDC, Medicaid, and SSI recipients and others who are eligible on the basis of low income.

The Detroit Area Agency on Aging is a nonprofit agency that funds, coordinates and monitors services for the elderly in the Detroit area. This agency serves the city of Detroit plus eight other areas: Hamtramck, Highland Park, Harper Woods, and the five Grosse Point communities. It administers a range of services including day care services, escort services, information and referral, health screening, in-home services (chore and homemaking), legal aid services, library services, minor home repair, nursing home monitoring, outreach services, senior center staffing, services for the visually impaired and hearing impaired, nutrition services (congregate and home-delivered meals), and transportation to nutrition programs. The agency also funds several other agencies in the city of Detroit: the Department of Health (nutrition and health screening services), the Public Library, the Recreation Department (day care), and the Senior Citizens Department (Information and Referral).

According to 1980 census figures, there are 230,823 elderly households above the poverty line. An additional 38,697 households that are below the poverty threshold in the area served by the Detroit Area Agency on Aging make up approximately 17 percent of the area's households. The 10,055 persons receiving adult services from the Department of Social Services thus constitute approximately one-fourth of the area's poor elderly households. Between 66 percent and 95 percent of the recipients of major services provided by the Detroit Area Agency on Aging (nutrition, in-home services, senior centers, information and referral) are low-income elderly.

Richmond

Richmond's Department of Public Welfare houses the Bureau of Social Services and the Bureau of Financial Assistance. Adult Services, including in-home supportive services, adult day care, and adult protective services, is a unit in the Bureau of Social Services. The Bureau of Financial Assistance includes the income maintenance programs—AFDC, aid to the aged, and aid to the disabled—and also handles eligibility for the related medicaid and food stamps programs. Approximately 55 percent of Adult Services recipients are elderly; 99 percent receive Medicaid and 75 to 85 percent, food stamps. The persons served are thus overwhelmingly low-income.

The Richmond Area Agency on Aging maintains purchase-of-service contracts with two agencies that provide transportation; two that provide outreach; twenty-five, congregate meal sites; and one agency each for in-home care, chore maintenance, telephone reassurance, legal, home-delivered meals, and employment services. The agency directly provides emergency support, some health services, and administrative and technical assistance for contractors.

According to the 1980 census, there were 43,693 households in the Richmond standard metropolitan statistical area (SMSA) with a household head sixty-five years old or older. These households represent 16 percent of all households in the Richmond SMSA. Of these, 42 percent (18,262) are single-person households. Those with incomes below the poverty level make up 28 percent of elderly households (12,234); similarly, 28 percent of all one-person elderly households were below poverty (5,094). Richmond's average in-home services caseload of 30 per month thus touches only a very small percentage of poor elderly, many more of whom are in need of assistance, judging from the city's 376 new cases of adult protective services complaints in 1983.

Boston

According to the 1980 census, there are 220,129 elderly households in the Boston metropolitan area—approximately 17 percent of the population. Of these, 25,232 households had incomes below the 1979 poverty level. The annual report of Boston's Commission on the Affairs of the Elderly, the local Area Agency on Aging, shows that in fiscal 1983 the commission reached 45,371 elderly clients with services, outreach, or information and referral. According to these figures, the commission had contact with approximately one-fifth of the area's elderly population. Program data on direct services provided by the commission in 1982 shows that 15 percent of the persons

served lived below the poverty level and 11 percent had a minority background.

Boston's Commission on the Affairs of the Elderly has been the city's Area Agency on Aging since 1978. It offers the same range of direct and contracted services for the elderly as the similar Area Agencies on Aging in the three other cities included in this analysis. Services in the Title XX-social services block grant are provided in Massachusetts by a separate program—the home care program—run by the state's Department of Elder Affairs. In the Boston area, three Home Care Corporations funded by this program provide social casework services, in-home supportive services, adult protective services, and other miscellaneous services for low-income elderly persons. Those with incomes under $5,200 receive free services while elderly persons with incomes up to $8,464 receive services on a sliding-fee basis. The 8,243 elderly served during fiscal 1983 make up about one-third of the poor elderly households in the Boston area.

Relations between the commission and the home care corporations have become more complex as funding from the Older Americans Act has leveled off. The home care corporations now contribute approximately one-third of the revenues to the home-delivered meals program run by the commission.

Both the commission and the home care corporations are local extensions of state agencies serving the elderly. The same is true of a third agency important to the low-income elderly—the Department of Public Welfare. The department administers Medicaid, food stamps, SSI, and other means-tested programs. Case managers working for the commission and the home care corporations often help elderly persons negotiate the eligibility procedures they encounter at the Department of Public Welfare.

Impact of Budget and Program Changes

The interviews with service providers, funders, and advocacy groups in the four selected cities reveal more pressure on services and more difficulties for continuing and new recipients than the budget and caseload figures indicate. In many instances, state or local decisions about funding or priorities exacerbate federal actions. Regulatory or administrative changes in federal programs besides those administered by the adult social services agency or Area Agency on Aging also affect the low-income elderly—sometimes directly and sometimes only by the increased anxiety or uncertainty they create. In the remainder of this chapter we address the cumulative impact of changing programs and policies on the low-income elderly in each of the four cities.

San Diego

Looking first at the major programs serving the poor elderly, we note that San Diego's Adult Social Services unit of the Department of Social Services has experienced substantial cuts. Services consist of in-home support, adult protective services, and conservatorship. In-home support services help aged and disabled persons to remain safely in their own homes by providing cleaning, washing and shopping, food preparation services and cleanup, and help with dressing, bathing, walking, getting into and out of bed, and toileting. Adult protective services, as defined above, assist adults who are neglected, exploited, or who are in circumstances that may endanger their health and safety. Social workers assess the need for services, provide short-term problem solving, assist in finding appropriate out-of-home living arrangements, and provide for other services such as financial aid, medical help, transportation, and homemaker assistance. The objective of this program is to remove or alleviate abuse and danger as quickly as possible and then link the adult to other resources so that any ongoing needs for counseling, supervision, and support services are met.

The fiscal 1982 adopted budget is 5 percent smaller than the fiscal 1981 budget and dropped another 12 percent in fiscal 1983. These decreases followed budget cuts of 20 percent between fiscal years 1979 and 1981, and thus were particularly difficult to absorb. For in-home supportive services, paid for largely by the social services block grant, caseloads went from 34:1 in fiscal 1980 to 52:1 in fiscal 1983. In addition, staff dropped 25 percent between fiscal years 1981 and 1983. Caseload dropped 8 percent in the same interval. Caseload is expected to hit 120:1 in fiscal 1984 because of even more staff cutbacks. Services cut entirely include home visits to supervise impaired and home-bound elderly, noncritical medical transportation, and all protective services related to drug and alcohol abuse. With recipient counts of approximately 6,500 per year, San Diego's in-home supportive services appear to reach the equivalent of half the poor elderly individuals in San Diego. Some of this support goes to nonelderly people, of course, but the penetration of services is still impressive.

Since these services are aimed at preventing or delaying institutionalization, cutting back on them may be fiscally shortsighted. In-home services are much less expensive than nursing home care, yet persons cut off from in-home support may enter nursing homes sooner and cost both federal and state governments more in eventual Medicaid expenditures.

Eligibility for services provided by the social services block grant carries with it MediCal eligibility, but with a $140 per month copayment obligation. San Diego's Adult Services unit advises people to apply their copayment to

homemaker services and receive MediCal coverage "for free." Actually, what happens is that for the same dollar outlay an elderly person receives both homemaker services and MediCal coverage, rather than just MediCal.

Adult Protective Services (with Title XX-social services block grant funding) lost 26 percent of its staff and reduced recipient load by 29 percent from 1982 to 1983. Thus the caseload size per staff person is stable, but significantly fewer people are served. Records are not kept of the number of referrals, so they it is not known whether the need for these services has increased or remained the same. The staff has cut caseloads by refusing all cases that appear to require more than six months to stabilize. (Adults in need of protective services are in emergency situations, which require intensive casework and which may take many months to resolve.) The staff refers long-term cases to other agencies but does not know if these elderly people actually receive care. This means that the county has stopped serving elderly people whose condition places them at continuing and long-term risk of illness or death through neglect, abuse, or inability to care for themselves.

San Diego's Adult Services unit also runs a conservatorship program for elderly and other disabled adults who are found to be incapable of taking care of themselves. Case numbers for the conservatorsip program have remained at around 1,900, but the staff has shrunk from thirty-eight to twenty-seven persons (a decline of 29 percent). State funds have replaced Title XX funds for this program at a reduced level. The unit has coped by dividing the cases into categories of persons assisted—"intensive," "minimal," or "stable." Thirty-six percent of the cases have been logged as persons having minimal need. These are "elderly in institutions with poor prognosis," people who will receive fewer social work services less often. Some elderly with minimal need and some stable ones in board-and-care homes will be moved from the conservatorship program to other units of the Department of Social Services or to state supervision.

Programs funded by the Older Americans Act are managed by the San Diego Area Agency on Aging. According to this agency's administrators, these programs have not suffered any significant cuts and some budget components have increased. (Their actual budget numbers, described below and in Table 30, tell a somewhat different story.) The agency anticipates being able to maintain its level of services to all senior citizens. The federal share of the agency's budget dropped 1 percent in nominal terms and 11 percent in real terms from fiscal years 1981 to 1983. In the same period the county share dropped 43 percent (48 percent after inflation), but the state share rose 174 percent after inflation. This latter increase was due largely to San Diego's three-year demonstration, the multipurpose senior center project. Although fiscal 1982 was the third (and presumably last) year of this project, the county

budget planning showed the program as continuing and legislation was under consideration to extend the project concept statewide.

Specific federal programs operated by San Diego's Area Agency on Aging experienced significant changes from fiscal 1981 to fiscal 1983: Funding provided by the Comprehensive Employment and Training Act was completely eliminated; revenue sharing (used largely for nutrition) dropped 34 percent; social services Title III(B) decreased 26 percent; nutrition programs, Title III(C) and U.S. Department of Agriculture, rose 38 percent. The agency's drop in social services funding adds to the picture painted by the Adult Services unit of strained social services resources. With both major providers of in-home care, adult day care, chore, maintenance and personal care, and case management experiencing significant drops in service levels, the elderly who rely on them for services are sure to suffer.

Other goods and services affecting the elderly include transportation, housing, and energy assistance. The feeling in San Diego is that federal low-income energy assistance has not helped most low-income elderly since most do not own their homes. The public housing authority reports a stable allotment of approximately 2,700 Section 8 subsidy slots. The renter's share of the cost has increased from 25 percent to 30 percent of income for new renters (current recipients must pay increases of 1 percent each year up to 30 percent). With almost 13,000 elderly persons in poverty in San Diego county, available housing subsidies do little to fill the housing need. Transportation to meal sites and nonemergency medical care have been cut by several agencies, making it harder for the elderly to get to services even when they exist.

Changes in MediCal and Medicare have also affected the elderly. Caseworkers in San Diego report elderly persons forgoing hospital treatment because they cannot afford the $304 copayment required by Medicare. Outpatient treatment is also more frequently postponed or forgone because senior citizens cannot afford the $140 copayment obligation and are afraid of having liens placed on their property or income. MediCal once picked up this difference for some recipients but no longer does so. Recipients of SSI and Social Security Disability Insurance are also now being held to the $140 copayment obligation and usually cannot afford both board and care or other residential payments and medical bills. MediCal's utilization review process is also reported to be limiting hospital stays, so that people awaiting nursing home placement are now being discharged from hospitals whether or not they have a nursing home to which they can go. Often these elderly end up in completely inappropriate board-and-care facilities in the interim.

Since no single agency in San Diego is responsible for the low-income elderly, no one can make definitive statements about how many are affected by federal changes or how severely. The percentage differences in funding

levels are small except for social services, but the general feeling is that there are serious difficulties.

Detroit

From fall 1979 until the time our data were collected, Detroit has had double-digit unemployment; in November 1982 it hit 20 percent. The demand for social services and health and welfare benefits has increased accordingly, while human services funding from both the federal and state levels is diminishing. Between fiscal years 1980 and 1983 Detroit lost $163.7 million in federal funds, a decrease of 45 percent. In the human services alone (AFDC, food stamps, Medicaid, health, nutrition, social services), the state of Michigan lost $421 million in fiscal 1982.

As a result of the structure of services in the Detroit area, it is difficult to isolate services utilized specifically by the low-income elderly. While we do have some caseload data for the major social service programs for low-income persons such as Medicaid and food stamps, which the elderly are likely to use, we do not have the recipient figures by age bracket. Furthermore, all publicly funded services designed specifically for the elderly in the Detroit area are administered by the Detroit Area Agency on Aging—including those operated by the city government. Although the majority of the agency's services are utilized by elderly persons of all income levels, most service recipients have low incomes.

According to the Detroit Area Agency on Aging staff, there have not been substantial changes in the agency's services during the past few years. Service funding levels have not been altered except for a few minor changes. Beginning October 1983, the funding for a few services, such as small home repairs, was cut, and the money was shifted to homemaker, chore, and other in-home support services. Although more funds for services for the aged could easily be used, what they had seemed to be relatively stable.

Budget data provided by the Detroit Area Agencies on Aging show that cuts have occurred or will occur in home repairs, escort services, library, recreation, information and referral, and a few other services; increased funding is available for in-home services, day care, and all nutrition programs. Recipient populations remained constant or increased slightly in nearly every service category during fiscal years 1982 and 1983.

The recent experiences of two services funded by the agency shed some additional light on funding issues and demand for services to the elderly in Detroit. The staffs of these services—the home-delivered meals program, based in the Detroit Health Department, and the general information and referral program, based in the city's Senior Citizens Department—were asked

to describe service changes that they have implemented and to comment on general changes in services and on the effects of those changes on recipients in the community.

The home-delivered meals program is funded almost entirely with a grant from the Detroit Area Agency on Aging; the city contributes the space and a secretary. The elderly are eligible for the service only if they have a condition so disabling (temporarily or permanently) that they are unable to go to a congregate meal site. The program has enjoyed the agency's consistent funding during the past few years, although the staff plans to begin some fund-raising efforts in the private sector.

In 1979 the home-delivered meals program served approximately 1,600 persons. In 1980, in response to declining funds, the program staff reduced the caseload to 1,300, mainly by attrition; when recipients died or left the program, the staff did not replace them with people on the waiting list. Between 1981 and 1983 the caseload slowly rose again to 1,600. In fiscal 1984 the program planned to serve 1,600 persons out of public funds, plus an additional 200 persons who could pay. The waiting list remains very long—nearly 1,000 people—and the staff believes that this is a serious problem. Demand is definitely growing for home-delivered meals. As a result, the program has tightened eligibility requirements (for example, requiring more careful review of medical documentation) and has also begun a periodic reinvestigation process. If a person's condition improves, the program staff may determine that the person is no longer eligible for meals, something that was virtually never done until recently.

The home-delivered meals program staff believed that money for meals was relatively stable but that there was not enough. Money for services to the low-income elderly is tight throughout the community, and demand for services is rising. Recipients of the home-delivered meals program are isolated, frail, and vulnerable—very old and very poor. For some, their only contact with the outside world is the person who brings the meals. As the program budget has been tightened, the staff has made a greater effort to put unserved persons in touch with the general information and referral program so that even if they cannot receive meals, they may be able to obtain some other in-home services such as homemaker or chore assistance.

The general information and referral program, in the Senior Citizens Department of the city, is funded by the Area Agency on Aging with a city match. The information and referral program provides information, referral, telephone assistance, advocacy, community organizing, and some casework. Half the agency's calls concern housing problems and the other half are a combination of problems related to health care, social security, nutrition, and transportation. While numbers of people served have remained approximately

constant in recent years, the program has been hard pressed to deliver services. The staff has been reduced from twenty-seven to eighteen persons. In addition, people now come to the agency with multiple needs and with problems that are more difficult to solve. Recipients of services need more casework now; merely providing phone numbers of other service providers is rarely sufficient.

Information and referral program staff were more pessimistic than the staff of the Detroit Area Agency on Aging about the recent changes in services and the general state of the elderly in Detroit. Housing is an "enormous problem." With new constraints on Section 8, the elderly in need of subsidized housing cannot receive help; waiting lists for senior citizen housing have been growing. Throughout the Detroit area rents are rising in units already occupied by the elderly. With a decrease in public funding for home repair services, the elderly are having difficulty paying their bills. One of the program's major advocacy efforts in 1983 was to persuade the gas company not to turn off elderly persons' utilities for nonpayment before April 15. The area's elderly are in "serious need" of assistance for energy bills. Cuts in recreation programs in the area have forced the aged to remain at home, increasing the demand for in-home services. In summary, the agency staff perceives that "basically, everything is getting tighter." Administrative changes in Medicaid, Medicare, and food stamps also contribute to the sense that there are insufficient resources to meet the need.

Richmond

Reductions in federal outlays for social services had the most direct impact on the low-income elderly in Richmond of all the Reagan domestic program changes. Cutbacks in Title XX-social services block grant funds at the state level translated into drastic reductions in chore and companion services and adult day care services in the city of Richmond because these services were nonmandated and relied on the purchase of service contracts. Many low-income elderly were forced to change their independent living situations in the absence of needed in-home supportive services. At the same time, the Capitol Area Agency on Aging received a moderate cutback in Older Americans Act funding between fiscal years 1982 and 1983, although overall funding for services remained steady.

In-home supportive services were the first and hardest hit by reductions in the social services block grant. The Adult Services Division's caseload for in-home services caseload dropped from an average of 343 recipients per month in fiscal 1981 to only 60 in fiscal 1982; the budget dropped from $615,000 to $162,000. Substantial cuts had come in fiscal 1979 also, when about 200 cases had to be dropped. The elderly were the population hit hardest,

decreasing from 169 to 26 recipients per month between fiscal 1981 and fiscal 1982. These cutbacks affected not only the low-income elderly recipients but the in-home support providers, too, who often were themselves low-income.

The Department of Public Welfare was sufficiently concerned about the cutbacks in in-home supportive services that it surveyed the 282 cases that it closed in July 1981 to find out how the people were now coping. The majority, 166 people, still lived on their own, but they still needed in-home supportive services. Thirty-seven had moved from their independent residence: nineteen into nursing homes, three into licensed board-and-care homes, three into unlicensed homes, seven into relatives' homes, and five to unknown locations. Forty were still receiving in-home services, four through volunteers and thirty-six through Capitol Area Agency on Aging funds (at a reduced level of services). Twenty-five had died, and four no longer needed services. The department had systematically made the necessary program cutbacks, reducing or eliminating services for those people judged most able to do without in-home help. The survey results clearly suggest that these "best off" people still need the service. The net result has been to shift the responsibility for these people to the private sector and to families. As the director of the Department of Public Welfare lamented: "The agency is now out of touch with the community's need for in-home services."

Funding for in-home supportive services is presently on the upswing in Richmond in response to the critical need brought out by Title XX reductions. The immediate response, in early 1982, came from the Capitol Area Agency on Aging and of United Way of Greater Richmond: the former directly paid $18,000 for in-home services for previous social services recipients; United Way made an emergency allocation to Family and Children's Services, a private provider of in-home services. Support from the private sector is expected to increase. In addition, the Department of Public Welfare is renewing efforts to meet the need for in-home services. It has secured $100,000 from the community services block grant and has received a share of additional state appropriations specifically for in-home services (funds transferred from Virginia's energy assistance program). There is also much debate about a state appropriation of $6 million to $11 million for in-home services earmarked in the state social services block grant budget. The legislature recently mandated in-home services on the condition that adequate funds were appropriated, so the state Board of Welfare recommended the earmark. Local welfare officials do not like this arrangement because it only aggravates their allocation problems: it increases the mandates but does not increase the funds available for all social services.

Adult day care services include maintenance or improvement of physical functioning, rehabilitation, social contact, occupational therapy, health mon-

itoring, and other services. The respite that families receive from twenty-four-hour care of elderly family members during the hours of adult day services is also an important function. Although Title XX support for adult day care was never extensive in dollar terms, its elimination in 1981 in Richmond meant drastic changes for many elderly and for many adult day care centers. Day care in Virginia serves about 0.5 percent of the impaired elderly, approximately 400 people. In Richmond, there are facilities for 145 persons in four adult day care centers, three of which serve almost exclusively frail older people.

To compensate for the Department of Social Services' cutbacks in in-home supportive services and elimination of adult day care services, the Capitol Area Agency on Aging shifted funds to provide these two services between fiscal 1982 and fiscal 1984; simultaneously, Richmond's share of these services increased, especially in in-home services. The Capitol Area Agency on Aging dropped a homemaker program after fiscal 1982 because the private agency with which it had a contract to purchase personal care services was able to obtain Title XIX reimbursement after fiscal 1982. United Way also increased its support for adult day care programs.

Cutbacks in funds for Title XX-social services block grant and Older Americans Act services have had less but still noticeable impacts on several other services for the low-income elderly. Transportation has become more expensive for individuals because (1) Medicaid reimbursement for transportation is more limited; (2) federal grants to the local bus company decreased, so rider fees increased; and (3) the Social Services Bureau has been overwhelmed by requests for bus tokens (normally given for travel to agency appointments, to a doctor, and to day care) and is in the process of restricting usage.

In the health area, Medicaid changes have affected the low-income elderly in several ways. Medicaid no longer covers special wheel chairs, eyeglasses, certain dietary supplements, and prescriptions; it covers fewer transportation costs than previously. Medicaid restrictions are also indirectly affecting the health clinic services available to the elderly; the Health Department has stopped accepting new elderly persons at the clinics because it lacks sufficient staff to tend to the necessary home visits. Medicaid will not cover the needed nurse practitioners.

Virginia's Medicaid program has also discontinued podiatry and eye services coverage, except for eye examinations; instituted a deductible and copayment system for services delivered to the medically needy; restructured the program's pharmacy reimbursement system; and limited hospitalization to one day before nonemergency surgery unless there are medical reasons for longer stays. Medicare changes noted elsewhere in this book affect Rich-

mond's elderly also. Increased copayment requirements are the most threatening to elderly persons whose incomes are barely adequate to meet daily expenses.

Housing is another area in which the low-income elderly in Richmond face increasing difficulty. Waiting lists have always been long for housing for the elderly, but there are indications that the situations is getting worse. The resource coordinators of the Capitol Area Agency on Aging, who work in local areas to help elderly persons obtain the services they need, see an increasing numbers of requests for housing assistance. Similarly, the Metro Alternatives Project identified housing services as one of three services in the most jeopardy: "Elderly, handicapped, and/or mentally retarded or emotionally disturbed individuals, as well as low-income people, may be forced to compete for already scarce low-cost, habitable shelter. The problem is further exacerbated by the lack of sufficient emergency housing services, the second highest emergency service request." In response to the growing need for housing, this agency and a consortium of Richmond churches are separately working to set up home-sharing programs for the elderly.

Nutrition is a significant service need of low-income elderly people in Richmond. Congregate meal sites are extensively supported by the Capitol Area Agency on Aging; primarily using Older Americans Act-Title III funds, the agency provides meals at twenty-three sites, including transportation to bring the elderly to the sites. The agency also arranges by contract for the home delivery of 175 meals per day in the Richmond area, and the meals-on-wheels program serves an even greater number; as more people of limited mobility try to stay in their own homes, the demand for home-delivered meals increases.

Two other service programs that underwent changes in response to the needs of the low-income elderly are transportation and emergency services. Transportation funding has remained fairly constant but demands on it have markedly increased, consistent with other reports of transportation needs in the city. Richmond has also experienced a sharp rise in requests for emergency services, testifying to the critical needs facing elderly residents.

Simultaneous changes in these various services can have a substantial impact on an elderly person. The Richmond Adult Services staff estimates that 99 percent of the elderly served receive Medicaid and 75 to 85 percent receive food stamps. An example commonly used locally of the effects of federal changes is an elderly female SSI recipient in Richmond who is eligible for care in an intermediate-level nursing home but chooses to stay in the community. Medicaid will pay up to $7 per hour for in-home supportive services, but the recipient must contribute all but $208 of her SSI income and Medicaid will limit the number of hours of services she may receive.

Because the woman is eligible for nursing home care, SSI will pay approximately $450 per month; at that level, the woman is no longer eligible for subsidized housing, so she loses her Section 8 rent-subsidized apartment. She not only has to move, but because of what she must pay for Medicaid services, she does not have most of her SSI check to use for housing costs. Since she now has to pay more for housing (although she does not have the money), her net income is less and she becomes eligible for food stamps. She will probably also request home-delivered meals from the Capitol Area Agency on Aging. The living costs for this elderly person may be lower overall, but the costs to her and to the private sector have increased while public costs have decreased. The woman has also been put through a series of bureaucratic "Catch 22s" that are likely to leave her confused, anxious, and fearful about her future resources and ability to cope. If the net result is that she gives up and enters a nursing home (paid for by Medicaid), both she and the taxpayers will be ultimate losers in this eligibility maze.

Boston

In-home supportive services for the elderly in Boston were not adversely affected by cutbacks in Title XX-social services block grant funding, as was the case in the other three cities. This was because in 1972 Massachusetts instituted a home care program, which has become one of the most highly funded social services programs for the elderly in the country. When faced with Title XX-social services block grant cuts, Massachusetts decided to fund the home care program entirely with state money, at a level well above the 1981 funding level.

Created by state mandate, the program is geared toward encouraging the elderly to maintain themselves in independent living situations by providing needed in-home supportive services. This experiment has been highly successful. The program relies on local private nonprofit agencies to deliver services to the elderly.

Three community-based home care corporations in the Boston area act as case managers and purchasers of social services for the elderly. The program staff's primary responsibility is case management. The staff evaluates elderly persons by means of a comprehensive needs assessment and then draws up an individualized social services plan that includes companion, homemaker, choremaker, and transportation services. The actual service provision is subcontracted to local provider agencies. Homemaker services make up 80 percent of total expenditures for the home care program.

That the program is totally state funded and has received increased appropriations during the past two years may eventually have an effect on

the program's eligibility standards. In the past people aged sixty and older and who were SSI recipients or whose income was within the state's Title XX income limits were financially eligible for home care services. The basic program provided free services for elderly people whose gross income was $5,200 or less. The program also had a sliding fee schedule, which allowed the elderly with incomes between $5,200 and $8,464 to receive homemaker services, based on their ability to pay. The past practice has been that the elderly could not be denied services if they claimed inability to pay. Recently, however, the state legislature, concerned about the escalating costs of the program, has proposed more strict enforcement of eligibility standards in an effort to generate revenue.

According to the staff of the senior home care program, cutbacks and policy changes in other federal programs have had a number of indirect effects on the program. The staff explained that as the Title III(C)-Older Americans Act nutrition monies have stabilized and leveled off, the home care program has picked up some of the cost for home-delivered meal services. For example, in 1983 the program paid $200,000 to nutrition service vendors in the Boston area. This amount represented 31 percent of the budget allocated by the Boston Commission on the Affairs of the Elderly for home-delivered meals. The staff also mentioned that as the Medicaid standards for duration of care have become stricter, the program has received more referrals and has increasingly picked up social services functions previously provided by Medicaid.

The Boston Commission on the Affairs of the Elderly also manages all programs funded by the Older Americans Act. According to the commission's staff, services have undergone some significant changes in the past few years. The Omnibus Budget Reconciliation Act of 1981 eliminated funding for support services under the Older Americans Act, Title III(C) Nutrition Services. These funds had been used for site management and transportation. The responsibility for such activities was shifted to Title III(B) Social Services, but without providing additional funding. In order to continue nutrition transportation services, the agency decided to deemphasize recreational activities and services previously provided by Title III(B) Social Services monies. The commission instead allocated more money to what it considers essential services, such as health and legal services. From fiscal years 1981 to 1983 the commission increased funding for in-home services by 17 percent and funding for legal services by 15 percent.

Commission-supported agencies serving the elderly experienced a complex set of shifting priorities and funding losses at federal, state, and local levels (see table 29). In fiscal 1982 the reduction of the commission's available funds had as much to do with lack of state support and a 13.3 percent reduction in city matching funds as with federal funding cutbacks. It is true, however,

that in fiscal 1983 the rise in the commission's available funds was largely due to increased state and private funding.

We spoke to commission staff involved in the administration of nutrition services and to the staff at one of the local legal services agencies. They described changes they had implemented in their own services and commented on the general changes in services and the effects on recipients across the Boston area.

According to the commission's administrative staff, funding from Older Americans Act-Title III(C) has provided from $1.7 million to $1.8 million annually for the past three years, constituting about half of the nutrition services budget. Other funding sources include the surplus food and cash payment program, funded by the U.S. Department of Agriculture, and the elderly lunch program, funded by the State Department of Education. The six nutrition sites in Boston are autonomous and operate on a direct reimbursement basis. The program also receives funding from Medicaid reimbursement, and some staff is provided by existing on-site agencies such as the Salvation Army.

When support services funds were removed from Title III(C) in 1981, the response of the program staff was one of panic. The program has fared better than the staff expected, although it was necessary to drastically reduce the social and recreational services previously available at the nutrition sites. In response to this, program staff chose as new nutrition sites locations at which existing social services agencies were already on site and providing these services.

The commission's nutrition services staff explained that the elderly population it serves has changed significantly over the past five to ten years. Today, the typical participant is more than seventy-five years old. Service needs have changed, consequently, for with increased age there are fewer well elderly and more elderly with health impairments; the demand for home-delivered meals goes up accordingly. The number of elderly people receiving home-delivered meals increased from 1,281 in 1982 to 2,300 in 1983; an increase of 80 percent.

The commission's perceived need for increased funding to support legal services is due in large part to federal cutbacks borne by the Legal Services Corporation. The overall reduction has adversely affected the agency's service delivery. The staff has been reduced from seven to three full-time attorneys, making it necessary to rank services and to become more restrictive in the kinds of cases acccepted. For example, the program no longer handles consumer cases nor offers financial management advice or counseling. The staff now gives more legal advice than actual representation.

According to the legal services program staff, there has been a sharp increase in the number of SSI eligibility redetermination cases. The staff

explained that the regulations regarding SSI eligibility had changed little, but the interpretation and administration of the regulations had changed due to the Omnibus Budget Reconciliation Act. Typical cases involved tighter eligibility requirements, which required stricter medical documentation and narrower income limits with back payment penalties. Current enforcement of an elaborate appeals process means that it now takes a longer time to appeal SSI eligibility redetermination cases and it is more difficult to resolve these cases. In the meantime, the affected low-income elderly are in need.

The Reagan administration's domestic program changes and subsequent funding cutbacks have had an impact on several other services for the low-income elderly in the Boston area. Boston's programs funded by the Department of Transportation have been severely reduced since fiscal 1981. In that year the city received approximately $11 million; by 1983 funding had dropped to $6.1 million, a 45 percent decrease. This large reduction in the mass transit operation assistance program has forced an increase in rider's fees. With public transportation becoming more expensive, there has been a greater need for subsidized transportation for the elderly. Use of the the commission-supported transportation service has increased more than 400 percent—from 79,373 trips in fiscal 1981 to 405,455 trips in 1983.

One of the service areas in which the low-income elderly in Boston have been hardest hit has been housing. With the virtual elimination of Section 8 rent subsidies and cutbacks in Section 202 construction loans, the commission estimates that approximately 12,200 low-income elderly are on waiting lists for subsidized housing in the Boston area. This means that a large proportion of the area's total elderly population is in need of rent assistance (Section 8) and low-rent public housing (Section 202/8) that includes special recreational and health care facilities.

Health needs have also been severely affected by federal changes. The commission estimates that health expenditures for the elderly in Boston are as follows: 38 percent of health care costs are paid by Medicaid, 20 to 30 percent are funded by Medicare, and 30 percent are out-of-pocket expenses for the elderly. The commission staff commented that out-of-pocket costs were taxing for many low-income elderly. With the massive program changes in Medicaid and Medicare, many elderly are troubled by the possibility of being unable to pay medical expenses.

Summary

Although real disposable income has risen for all elderly households between 1980 and 1984, changes made during the Reagan administration in federal programs and policies specifically affecting the low-income elderly

have not made life any easier for this segment of the elderly population. It is impossible to determine exactly how much harder it is for the low-income elderly to maintain a minimum standard of living and sense of security.

According to Moon and Sawhill, the real disposable income of elderly families and unrelated persons in the bottom two income quintiles rose between 5.9 and 9.2 percent from 1980 to 1984, but only 0.1 to 0.8 percent of this change is attributable to Reagan administration policies. Elderly households represent an anomaly in these lower quintiles, since all other family types lost real disposable income during the same years.[3] These authors go on to explain that the direct policy impacts on poor households reflected the loss of federal government benefits to households with incomes under $10,000. All low-income elderly would be included in this category. The average household with less than $10,000 income lost $217 in cash benefits and $158 in in-kind benefits, representing 4.3 and 3.2 percent of their income.[4] Thus policy changes in the Reagan administration policy changes have been estimated to have reduced the available resources of the poorest families, including elderly families, by 7.5 percent.

The sense of many service providers is that service cuts necessitated by less funding plus the tighter requirements and changed rules for a wide variety of federal transfer and insurance programs have placed the low-income elderly in a position of greater stress and uncertainty. If the intent of federal policy has been to protect the "truly needy," changes in federal programs have not reflected that intent, either with respect to single programs or collectively. State and local resources have in some instances compensated for federal losses, and this pattern could be said to be in keeping with the administration's preference for nonfederal determination of priorities for local services. However, the promise of *federal* protection for the truly needy and maintenance of *federal* effort on their behalf has not been met with respect to the low-income elderly.

Consistent findings in the four cities investigated indicate that changes in the major federal programs of Medicare, Medicaid, food stamps, housing, and transportation assistance have affected the low-income elderly in negative ways. Required copayments for Medicare tax the ability of these persons to live within meager budgets, with the result that in many instances they go without needed medical care. Changes in Medicaid rules governing eligibility raise the specter that even after an elderly person has spent all available cash,

3. Marilyn Moon and Isabel V. Sawhill, "Family Incomes: Gainers and Losers," in John L. Palmer and Isabel V. Sawhill, eds. *The Reagan Record: An Assessment of America's Changing Domestic Priorities* (Cambridge, Massachusetts: Ballinger, 1984), table 10.6 and figure 10.1.

4. Ibid.

that person will still not be eligible for Medicaid due to the presence of some fixed asset previously disregarded by eligibility determination procedures. Other Medicaid changes have increased the degree of disability or illness necessary before one is eligible for Medicaid-covered nursing home care (in Virginia) or decreased the time allowed for hospital stays (in California). Both changes mean that the low-income elderly must turn to community resources at a time when other federal changes have strained these resources to the breaking point.

Affordable housing is scarce, and many low-income elderly are on hopelessly long waiting lists for subsidized housing (as many as 13 percent of Boston's low-income elderly—12,000 people—are waiting for senior citizen housing). Cuts in transportation budgets and specialized transportation services for the elderly curtail daily activities and in effect confine many of these elderly people to their homes.

Social services for the elderly, particularly in-home supportive services such as homemaker, chore, home maintenance, companion, and personal care services, have suffered the largest direct cuts with the transition from Title XX to reduced funds under the social services block grant. Two of the cities studied cut these services significantly, and in both these post-1981 cuts followed a year or more of staff and service reductions due to state and local reductions. These agencies had no "fat" left to trim by the time federal funding reductions hit. A third city switched these services from Title XX to Title XIX (Medicaid) funding and increased the number of people receiving services, resulting in questionable net savings to the federal government.

In the four cities we studied, all programs have felt the pinch of the Reagan administration's approach to social programs. The Older Americans Act has been the most stable of the locally administered programs, protected as it is by the considerable political power of large numbers of older Americans of all income levels. Even within this program, funding for social services Title III(B) has declined in three of the four cities. Area Agency on Aging budget components deriving from the Older American Act have fallen between 4 and 11 percent in inflation-adjusted dollars. Some of these services, frequently social services, have suffered accordingly. Thus all sources of support and services for the low-income elderly have experienced cutbacks, largely because of federal changes, and agencies providing social services to the elderly continue to report pressures and strains on their capacity to meet the need.

CONCLUSIONS

We use the debate surrounding the issue of federal versus local control—that is, which level of government has the responsibility for protecting and supporting the truly needy—as the context in which we draw our conclusions. This book addresses the question, is the social safety net intact for some of the nation's most vulnerable people? More specifically, we investigate in four local jurisdictions the welfare of three needy populations—abused, neglected, and dependent children; the chronically mentally ill; and the low-income elderly. We ask whether states and localities have been able, and willing, to protect the well-being of these populations in the face of federal program and budget changes made during the early 1980s.

When President Reagan took office in 1981 he asserted the philosophy that his administration intended to use with respect to social welfare programs and the people who rely on them. He acknowledged that some people live in circumstances that leave them without the basic necessities of life. He said that the federal government would not desert the truly needy and asserted his commitment to the goals, if not to the means, of most social welfare programs. He espoused the position that except for the truly needy, social welfare programs and the populations served by them were better left to states and localities than to the federal government. Further, he promised to reduce federal government spending for social welfare programs. Finally, he asserted that a strong economy was the best form of social insurance, and committed his administration's efforts to improving U.S. economic performance and reducing inflation.

The Role of the Federal Government

In taking the positions just described, President Reagan placed himself firmly on the "local" side of a recurring policy debate about the relative

value of central versus local control over social welfare programs. This debate is decades old, as are the pendulum swings in policy and practice that accompany it. The issue of central versus local control is debated at all levels of government—between state and local governments as well as between the federal government and all other levels of government. Practical realities render the argument unresolvable, except perhaps as a philosophical preference.

A brief description of both central and local positions in the debate will set the stage for our findings regarding the effects of Reagan administration changes on the three vulnerable populations we studied. On the side of greater local control of resources and services, advocates advance the practical argument that social welfare is best provided at the local level because only local people know the needs of their area intimately and can make appropriate priority decisions for distributing resources to many potential recipients with different needs. They add the philosophical argument that social welfare began as a family and community function and ought to continue to be the responsibility of the people closest to those in need.

Arguments for local control have their greatest appeal when one considers the inflexibility and excessive bureaucratization that often accompany central control, and the frequently counterproductive incentives that federal funding categories create for local decision makers. Exceptional circumstances occur in individual cases, and situations develop that are reasonable but not allowable according to the rules. These cannot be accommodated in a rigid centralized system that must be administered similarly in all jurisdictions. Central control mechanisms, rules, and eligibility criteria begin to drive the local planning process, so that at the local level governments, providers, and interest groups begin to think only of federally fundable approaches and solutions rather than the most appropriate ones. Central control can also create uneven service coverage. Needy persons not covered by some federal program receive very few services. At the same time, there are children who receive foster care and elderly who receive nursing home care—not necessarily because they badly need that care or because placing them in those settings is good for them, but because federal or state dollars pay most of the cost of that care and the county or locality making the actual placement decision can thereby keep its own investment as low as possible. Supporters of local control state that if counties received the same dollar amount of federal and state input but were not tied to using it in specified ways, they could probably make the same dollars go a lot further and provide more optimum services for needy populations.

On the side of greater central control (federal or state, but in the present instance, federal), advocates point to inconsistencies of support and protection

for the needy across jurisdictions. Spokespersons for particular disadvantaged or disabled groups argue that the nation as a whole has some moral obligation to maintain minimum standards of living, health, and other services for members of these groups—abused children, the elderly, the mentally ill, or any other group of vulnerable people. Because support and assistance for these groups by local jurisdictions and states is documentably uneven, such that a person with a given disadvantage or disability may receive twice or three times as much assistance in one state or locality as in another, the federal government must become the protector of last resort. It must set minimum standards of assistance and provide the resources to meet these standards so that the nation as a whole can meet its obligations to care for the neediest citizens wherever they may live.

The arguments for central control appear strongest when one examines the very real inequities across jurisdictions experienced by persons with essentially identical needs. Both the ability and the commitment to help the truly needy vary across jurisdictions, as does the definition of the level of need itself. Communities differ greatly in their resource base and hence in their ability to raise tax revenues earmarked for assistance programs. Communities also hold quite different values regarding who needs and deserves help. Often these values parallel the interests of strong voting blocks; equally often, the truly needy are neither well-organized politically nor part of the political process at all (for instance, abused children, chronically mentally ill adults). Such issues as public safety and public roads have been the focus of county boards for much longer than social welfare programs, and these issues continue to exercise strong budgetary pulls in many communities, to the detriment of programs to assist disadvantaged or disabled people.

What Has Happened?

The ultimate questions on which we focus the findings of our study are, is the social safety net intact, and does it function equally well to protect the truly needy in all local jurisdictions? Are people who are without resources and who cannot help themselves at least as well off, in every jurisdiction, as they were before the Reagan administration instituted its many changes in federal social welfare activities? In particular, are the three populations we investigated, who appear to be truly needy by almost anyone's definition—abused, neglected and dependent children; the chronically mental ill; and the low-income elderly—suffering in significant ways from Reagan administration cuts or changes in social welfare programs?

In the introduction to this book we outlined seven poss'ble ways that the circumstances of needy people could have remained stable despite many

federal changes. Now we return to these seven possibilities and assess the extent to which they have occurred, thereby yielding continued protection for vulnerable individuals. The possibilities are (1) programs serving these populations remained intact, but programs serving other populations were cut or changed at the federal level; (2) programs serving these populations underwent significant restructuring at the federal level to more effectively serve the populations with less revenue; (3) action at the state or local level cushioned federal changes by increasing administrative efficiency; (4) local action protected these populations by shifting as many people as possible to federal programs less affected by cuts and changes; (5) the non-profit sector filled the gap at the local level; (6) local action protected these populations by making them high priority and shifting scarce resources to cover their needs; and (7) state and local governments raised revenues to compensate for federal cuts.

The first two possibilities are ways that the federal government might have fulfilled its commitment to protect the truly needy, thereby retaining some federal (central) role in providing the social safety net. The remaining five possibilities are ways that local jurisdictions might have acted to compensate for federal changes and maintain the social safety net. The discussion that follows assesses the extent to which each possibility became a reality. Taken as a whole, this assessment will reveal whether the shift to greater local control has benefited the needy people in the three populations studied.

Programs Affecting These Populations Did Change at the Federal Level

We have seen that, for each of our three populations, significant programs affecting their well-being *were* changed at the federal level. While maintaining written commitments to program goals, the Reagan administration cut funding for many programs and sought to repeal statutory authority for still others. With respect to abused, neglected, and dependent children, the administration sought unsuccessfully to repeal the Child Welfare and Adoption Assistance Act of 1980, and has consistently underfunded its provisions for preventive, supportive, reunification, and permanency planning services. With respect to the chronically mentally ill, the administration was successful in its efforts to repeal the Mental Health Systems Act of 1980, to cut funding for its services by approximately 25 percent, and to transform its structure into a block grant. It also significantly changed the eligibility criteria for Supplemental Security Income (SSI), which greatly affected the fortunes of many chronically mentally ill.

The administration has done least to directly affect the low-income elderly, although reductions in the availability of in-home services (funded through the social services block grant), increases in Medicare copayments, restrictions in Medicaid, and reduced availability of housing, transportation, nutrition, and others subsidies have all affected the well-being of this population.

Programs Were Not Significantly Restructured at the Federal Level

Programs serving the three populations we studied were far from perfect when President Reagan took office. Dissatisfaction with the quality and types of care available to abused, neglected, and dependent children and to the chronically mentally ill led Congress in 1980 to pass the Child Welfare and Adoption Assistance Act and the Mental Health Systems Act. Both legislative mandates were the result of extensive study of existing support programs and their deficiencies. Both were designed to remedy some of the more dysfunctional aspects of service delivery for the respective populations and promote their welfare. President Reagan's policies could have built on these reforms, or could have proposed even more extensive changes in system structures to more effectively and efficiently assist these needy populations.

Incentive structures arising from federal policies in existence before 1980 often promoted more expensive and less appropriate care for all three selected populations. Much more money was available to provide foster care for children in need than for preventive efforts to keep natural families together; similarly, greater funds were at hand to provide hospital-based care for the chronically mentally ill rather than supportive community-based services and to make possible nursing home placement for frail elderly people rather than in-home supportive services. The easiest and least expensive type of care from the county's viewpoint was usually the most expensive type of care overall and the most costly for the federal government—thus the needy were removed from their homes and placed in institutions. These actions often proved disadvantageous in human terms as well because they disrupted the lives of the needy and their connections with people, places, and communities. States had been using an even less expensive strategy for the chronically mentally ill—releasing them from state mental hospitals and providing no alternative care.

Clearly the incentive structures underlying service decisions for all three populations needed a thorough rethinking. Underlying the legislation and provisions of the Child Welfare and Adoption Assistance Act of 1980 was

the intent to alter the incentive structure for child welfare services—to discourage foster care and promote prevention and permanency planning. The Mental Health Systems Act contained provisions directing approximately 20 percent of its federal assistance toward services for the chronically mentally ill in the community. Medicaid and Medicare expenses were rising astronomically but ironically the programs would not pay for less expensive and more humane community-based care. Also, many programs for the elderly served all persons above a certain age, regardless of financial need, when some greater focus on poor or frail elderly persons might have been a more judicious use of public resources.

When President Reagan took office, his administration had ample opportunity to tackle malfunctioning incentive structures and make them both more rational and more humane. Other aspects of program structure might also have been addressed and redesigned. The evidence of this study indicates that little program restructuring took place. Rather, the administration simply provided less money for essentially unchanged programs, whether those programs remained under federal control or shifted to a block-grant format. Thus the opportunities for continued protection of needy populations through continued federal (central) control were not taken.

Some Local Agency Management Did Become More Efficient

Turning now to the possible ways that local action might have protected the well-being of needy people, we look first at efficiency—whether agencies simply became better, more streamlined, more efficient at providing appropriate services. The Reagan administration placed great faith in the ability of state and local operations to achieve efficiency gains and justified funding cuts with the reasoning that bureaucratic inefficiencies were absorbing large proportions of federal funding. Eliminating the federal role, so the argument went, would result in efficiency gains to offset budget reductions.

In two instances, confirmed by the providers themselves, greater efficiency did indeed occur. San Diego's child welfare services reorganized to place more emphasis on preventing placement in substitute care, and Richmond's mental health services reorganized into a clinic structure that serves more people better, according to all the people we interviewed. In addition, agencies serving the elderly in both San Diego and Boston improved interagency coordination by processing applications so that eligible persons could be better matched with different programs; other gains were seen in purchasing services through the agency that could deliver them most efficiently.

However, in none of these examples did changed operating structures fully compensate for dollar losses. In addition, these cases are exceptions to

the more basic finding, that seriously reduced funding occurred at a time when the demand for services rose, when agencies began to see more people and families with multiple problems, and when all types of resources for helping vulnerable people were shrinking. Agencies responded by cutting caseloads as much as they dared, although most did not cut in proportion to their reduced funding levels. Alternatively, agencies tried to serve more persons with limited resources, and each recipient got less from the agency. "Less" might mean less time spent on an investigation of child abuse, less time spent assisting families to resolve their difficulties so that children would not have to be removed from their homes, less time in a day program for mentally ill clients, less attention to the eligibility difficulties of the mentally ill when applying for assistance from entitlement programs, fewer social services for older people, or less help given to adults in life-threatening situations if their plight was not readily resolvable.

Many Local Agencies Did Shift the Financial Burden to Other Federal Programs

To increase their available resources as much as possible, most jurisdictions actively pursued the option of shifting people they served to federal entitlement programs whenever their characteristics matched relevant eligibility criteria. Of course, these actions thwarted rather than furthered the federal effort to increase local and state financing for social welfare programs. States and localities varied in the degree to which they switched recipients entitled to in-home services from Title XX to Medicaid (Title XIX) funding. Of the states we examined, Michigan pursued this course with greatest zeal, resulting in an increase of almost 50 percent in people served. States with Medicaid waivers for community-based services to prevent nursing home placement were more able to make this shift than others.

A number of states, including California and Michigan, shifted federal low-income energy assistance funds into social services, as permitted in the block-grant legislation. States and localities replaced Title XX day-care funding with income disregards authorized under AFDC (Title IV(A)). Finally, at least one state (California) interpreted new federal funding available for emergency services for children as applying to crises involving child abuse and neglect. They charged their regular crisis intervention services heavily to this program until federal officials rejected the state's interpretation and refused to pay.

Despite all these efforts to shift the financial burden back to the federal government, states and localities shouldered most of the burden of replacing lost federal dollars. The budget and caseload figures given throughout this

book include increases from other federal funding sources (if the jurisdictions examined were able to find such resources), yet the fact remains that agencies faced greater need with fewer resources.

The Nonprofit Sector Filled Some, but Not All, of the Gap

Many services for the three populations are delivered by nonprofit agencies. Payment structures are such that local government supplies the funds and nonprofit agencies deliver the services under contract to county or city agencies. In the four jurisdictions under investigation in this study, the nonprofit agencies hit by cuts in government contracts tried to compensate largely by increasing fees—shifting to a population that could pay for services. In only one instance did private philanthropy clearly step in to compensate for some (but not all) lost government revenue—that was the case of the Richmond local United Way shifting support into more in-home services for the low-income elderly.

Nationally, nonprofit agencies as a group behaved much as those in the four jurisdictions. Another Urban Institute study reports that nonprofit agencies that did manage to offset losses of government funding did so by increasing commercial sources of income (fees and product sales). Nonprofit agencies serving the neediest were least able to do this, ending up with the largest overall revenue losses. The net result appears to be a shift away from nonprofit agencies' service to the neediest people.[1]

Local Government Responses: Priorities Shifted and Revenues Increased, but Not Enough

We have just seen that five of the seven possible ways to protect the truly needy while cutting federal programs have not been consistently put into effect, nor have they been able to fill the gap left by decreased federal support. The remaining options are the most important in the context of policy debate on the relative merits of local versus central control of social welfare policy. Did state and local governments compensate for cuts and changes made at the federal level, either by shifting priorities among service recipients or by raising revenues to replace lost federal funds, so that services for these three needy populations were maintained?

To summarize our findings on this issue, we compiled the budget changes from fiscal years 1981 to 1983, adjusted for inflation, for agencies serving

1. Lester M. Salamon, "Nonprofits: The Results are Coming In," *Foundation News* (July-August 1984), pp. 16–23.

the three selected populations in our four local jurisdictions. These figures appear in table 31, along with caseload changes during the same period.

Looking first at the "Total" column in the table, we see that two jurisdictions, San Diego and Richmond, show consistent and rather sizable re-

TABLE 31

SUMMARY OF BUDGET CHANGES AFTER INFLATION AND THE CASELOAD CHANGES FOR VULNERABLE CHILDREN, THE CHRONICALLY MENTALLY ILL, AND THE LOW-INCOME ELDERLY IN THE FOUR SELECTED CITIES, FISCAL YEARS 1981–83
(*Percent Change*)

City and Type of Service	*Budget Change*					*Caseload Change*
	Federal	*State*	*Local*	*Fees and so on*	*Total*	
San Diego						
Adult social services	−6	10	−44	*	−24	−13
Area Agency on Aging	−11	174	−48	38	1	21
Child intake services	−12	*	−21	430	−16	29
Placement and supervision	8	*	−30	−34	−17	−5
Mental health	*	−26	45	6	−13	6
Detroit						
Adult social services	−36	43	*	*	8	8
Area Agency on Aging	−4	34	−69	*	−1	−3
Children's services	n.a.	n.a.	n.a.	n.a.	n.a.	60
Mental health	−29	10	9	−17	4	32
Richmond						
Adult social services	−32	−38	−38	*	−34	−15
Area Agency on Aging	n.a.	n.a.	n.a.	*	−14	10
Foster care	−11	*	−18	*	−14	−2
Protective services	−64	*	−70	*	−65	167
Mental health	*	11	−19	−60	−17	18
Boston						
Adult social services	−100	64	*	*	7	7
Area Agency on Aging	−6	*	−17	*	−8	112
Child welfare	−22	30	*	*	7	6
Mental health	−7	−24	*	*	−23	n.a.

SOURCE: Tables 5–8, 16–21, and 28–31.

n.a. Not available.

* No money from this source.

ductions in funding for all services. Service funding in Detroit held steady or increased slightly, and Boston shows a mixed pattern of increases and decreases. Data in the "Federal" column indicate that federal funding for all services in all cities decreased. The next three columns show the source of replacement resources. The most obvious pattern in these columns is that state governments provided the lion's share of replacement funding while the local governments were more likely to cut their own investment in these services than to increase it.

Before commenting in detail on the budget picture revealed in the table, it is necessary to complete the analysis by examining caseload changes. It is possible, after all, that funding reductions followed from reduced need and that they do not reflect a reduced commitment to serve needy populations at all. As can be seen from the last column in table 31, in only one instance did caseload size shrink in proportion to funding cuts (Detroit's Area Agency on Aging). In three cases (adult social services of Detroit and Boston and Boston's child welfare services), caseload increased in proportion to funding increases. In all remaining cases (thirteen of the seventeen services examined in the four cities for which data are available), agencies emerged from budget changes with increased ratios of people served per dollar available. Sometimes these ratios are extremely skewed, such as San Diego's child intake service, which suffered a total budget reduction of 16 percent but faced an increased recipient load of 29 percent, or Detroit's mental health services, which served 32 percent more people with a budget increase of only 4 percent.

Based on the caseload data summarized in table 31, it is reasonable to conclude that budget reductions occurred despite continued or increased need for services, not because demand slackened. The anecdotal data presented in chapters 3, 6, and 9 on waiting lists and unserved needy persons in each of the four jurisdictions further reinforce the conclusion that the need for service still exists or has increased. In addition, where agencies have conducted follow-up studies to assess continued need among those for whom services were reduced or eliminated, they have found that the need has remained at the same level or has increased. Richmond's Adult Services unit interviewed almost 300 of its "least needy" cases, for whom in-home supportive services had been terminated due to reduced program funding. Most were found to still need services, and many had been forced to enter more expensive levels of residential care because they no longer received in-home services. New York State's follow-up study of individuals removed from the SSDI/SSI roles revealed that virtually all such people, declared by the Social Security Administration to be employable, remained unemployed and without income, and that many had applied for state and local welfare.

Resources and Commitment

If we view state or local action to replace lost federal revenues as a result of two factors, resources and a sense of values or commitment, we have a final basis for assessing the results of the current movement to local responsibility. Michigan, the state in our sample with the worst economic circumstances and the least favorable revenue situation during the period under consideration, did the most to protect all three of the vulnerable populations of interest in this study. Michigan has a long history of liberal social welfare spending, and the state's values and commitments clearly directed its attempt to find the resources, even under constrained economic conditions.

California and Massachusetts, both states with legislation inspired by taxpayer dissatisfaction, behaved very differently. Both protected the elderly; Massachusetts compensated for lost child welfare funding; and both reduced spending for mental health even further than federal cuts. The state of California and San Diego County together did not fully compensate for federal losses for any of the three needy populations. In this matter, San Diego County was the chief source of revenue loss. This jurisdiction, pursuing the same philosophy that the Reagan administration espouses with respect to individual responsibility, not only did not replace federal funds but cut its support for social welfare services even further. In both these states, and in San Diego as a local jurisdiction, values and commitments overshadowed ability to pay. Neither state, nor San Diego, suffered badly from the recession or unemployment; both states are traditionally liberal supporters of social welfare programs. Massachusetts protected two out of three of the populations we studied. This was possible because Massachusetts administers its social welfare programs from the state level, so state action was all that was required. In California local jurisdictions have a considerable amount of control over their social welfare programs. San Diego County, on the strength of its own values, acted to cut social programs even though it had the resource base to do otherwise.

In Richmond cuts came from both the state and local levels, reflecting philosophy more than resource base. Virginia did nothing to compensate for federal cuts in most of the services we investigated. As a consequence, Richmond sustained all the federal cuts, and the city added proportional reductions of its own.

Central versus Local Control for the Three Needy Populations

Our final assessment of whether the social safety net was intact during the 1980s, made in the context of the central versus local debate, is that the

three vulnerable populations in this research representing the truly needy have *not* been uniformly protected by state and local decision making in response to federal program reductions. We have presented evidence from four jurisdictions showing that these populations received less service, from agencies under more stress and struggling to meet increased need, than they did before federal changes went into effect. States and localities have responded more on the basis of values and philosophy than on the basis of resources—when they thought the services were important, they found the resources; but when they did not place a high priority on the public's responsibility to protect and support fellow citizens in need, they withdrew resources from those functions even when the resources could have been made available. We conclude on the basis of this evidence that federal involvement is still critical to assure equitable treatment of these vulnerable people who cannot protect themselves. Federal withdrawal from that involvement has resulted in poorer services to fewer people and made the availability of those services contingent on the values and priorities of a jurisdiction.

The Reagan administration for the most part has not restructured federal programs in ways that increase achievement of program goals in comparison to pre-Reagan achievement. Rather, these programs have simply received less money to do the same job in the same way. The administration repealed key provisions of the Mental Health Systems Act. It has repeatedly sought repeal of the incentive restructuring aspects of the Child Welfare and Adoption Assistance Act, and has underfunded components of the act in ways that hinder the restructuring it was designed to accomplish. Among the programs we examined for our three populations, only community-based care for the frail elderly has seen significant innovation at the federal level. The Omnibus Budget Reconciliation Act of 1981 established opportunities within Medicaid for states to use this funding to provide community-based care in order to delay or prevent nursing home placement. One of the selected jurisdictions used this mechanism to protect some persons whose ability to remain in their own home would otherwise have been jeopardized by cuts in the social services block grant.

The administration's basic position on redressing the federal-local balance in favor of state and local emphasis has been its only "restructuring" effort. It has not conducted detailed program reviews for federal programs serving the three populations that resulted in substantial rethinking of program structures or incentive systems. To the extent that the administration has failed to take advantage of its opportunity to restructure, it has failed to make programs more responsive to the needs of the people they are designed to serve. Coupled with reduced resources for program services, this lack of program responsiveness and restructuring has translated into a lower likelihood

of assistance to needy people at the local level, and a higher likelihood that people with similar needs will receive different levels of assistance, depending on where they live. We conclude that the needy people in the three populations we studied have suffered as a result of federal changes and local response.

"Burt and Pittman examine the impact of recent government retrenchments on abused and neglected children, the chronically mentally ill, and the low-income elderly. The authors conducted their investigation the old-fashioned way; instead of relying on sanitized regressions and computer spread sheets, they collected an impressive inventory of facts in four diverse communities. The result is a comprehensive, meticulous, and authoritative assessment of what has happened to America's truly needy. Policymakers, social service providers, students of social work, and all of us who care about the vulnerable in our society will find *Testing the Social Safety Net* indispensable."

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Columbia University School of Social Work

"Evidence from local communities of the gaping holes in the safety net for abused, neglected and dependent children gives cause for great concern about the future for services to other vulnerable groups of children. Such findings cannot be ignored by a society which professes to care for those least able to help themselves."

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President
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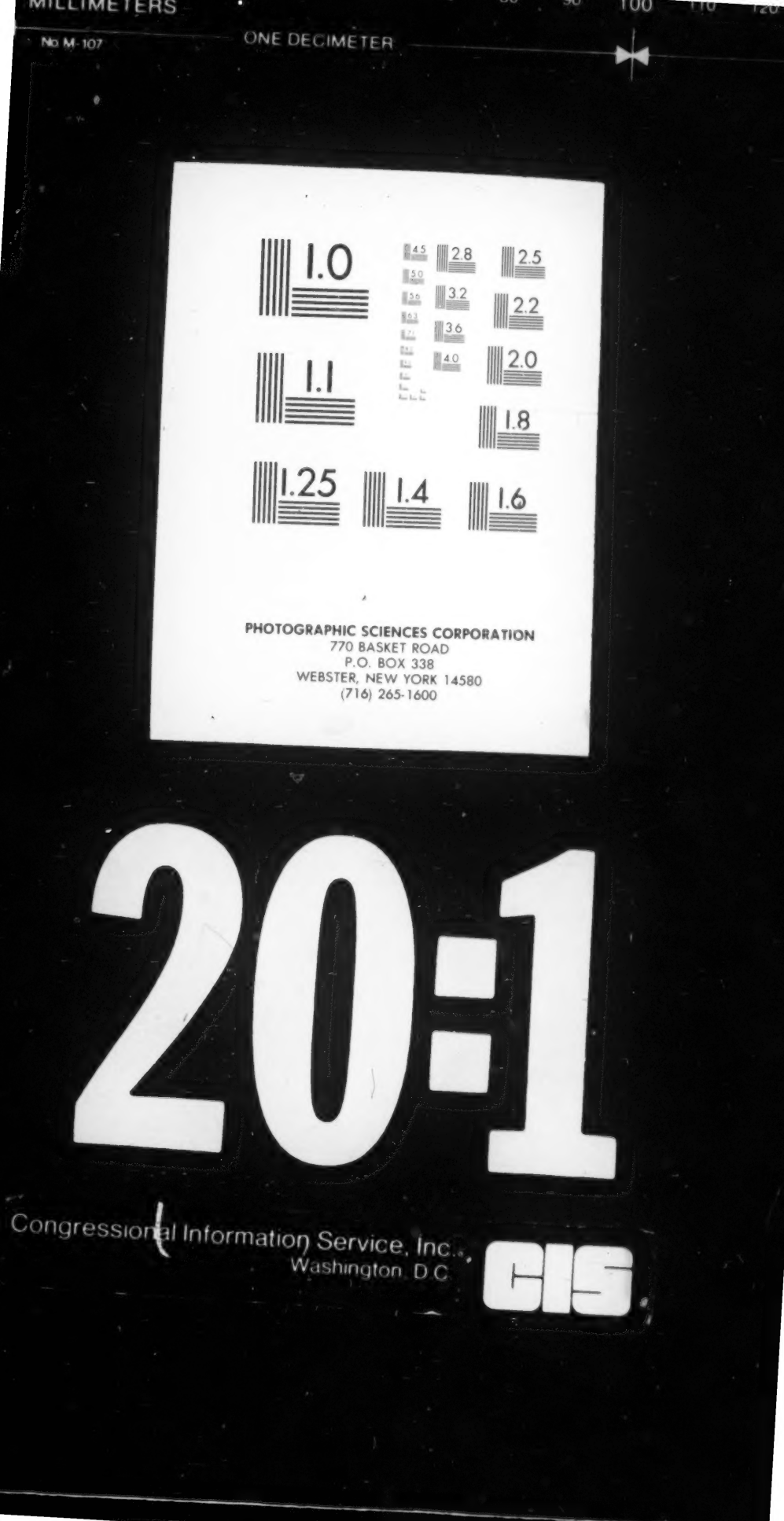
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